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AUTHOR Pennell, Frances E.; Brown, Sharan E.
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ABSTRACT

This manual provides Washington state consumers and their advocates with information and guidance to enable them to pursue appropriate avenues for funding assistive technology (AT). Chapter 1 discusses the legislative history of AT, the definition of AT, and basic funding strategies. Chapter 2 reviews health-related sources of AT funding including private insurance, Medicaid, Medicare, the Children's Health Insurance Program, Washington state basic health care plans, and Washington state's high risk pool. Chapter 3 describes funding options for individuals who need AT for work or to prepare for employment. It provides an overview of the rights of people with disabilities to have AT and major sources of funding for work-related AT. Chapter 4 describes the rights of students with disabilities to AT in education, including public and private elementary and secondary schools and higher education. It also discusses other options for funding AT for students with disabilities. The following chapter discusses AT for special populations. Chapter 6 provides basic information on how to appeal denials of requests for funding AT. The last chapter describes a number of alternative funding sources. Appendices include a list of relevant resources and a sample letter of justification. (Chapters include references.) (CR)

PAYING FOR THE ASSISTIVE TECHNOLOGY YOU NEED

A Consumer Guide to Funding Sources in Washington State

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*Washington Assistive Technology Alliance
Seattle, Washington*

*University of Washington
Center for Technology and Disability
Seattle, Washington*

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University of Washington Center for
Technology and Disability
BOX 357920
University of Washington
Seattle, Washington 98195-7920

800-841-8345 V/TTY (toll free)
206-685-4181 V/TTY
206-616-1396 TTY

uwat@u.washington.edu (email)
<http://wata.org> (on the Web)

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Authors:

Frances E. Pennell, J.D.
Funding and Policy Specialist
University of Washington Center for Technology and Disability

Sharan E. Brown, J.D., Ed.D.
Research Assistant Professor
University of Washington
College of Education

TABLE OF CONTENTS

| | |
|---|-----------|
| ABOUT THIS MANUAL | 5 |
| CHAPTER I | |
| ASSISTIVE TECHNOLOGY BASICS | 7 |
| I. A. Introduction | 7 |
| I. B. Basic Funding Strategies | 9 |
| Chapter I Notes | 16 |
| CHAPTER II | |
| HEALTH-RELATED SOURCES OF ASSISTIVE TECHNOLOGY FUNDING | 17 |
| II. A. Private Health Insurance/HMOs | 17 |
| II. B. Public Employees Health Insurance | 21 |
| II. C. Medicaid | 21 |
| II. D. Medicare | 25 |
| II. E. Children's Health Insurance Program (CHIP) | 29 |
| II. F. Washington State Basic Health Care Plans | 30 |
| II. G. Washington State's High Risk Pool | 30 |
| Chapter II Notes | 31 |
| CHAPTER III | |
| EMPLOYMENT-RELATED SOURCES OF ASSISTIVE TECHNOLOGY FUNDING | 33 |
| III. A. Employers | 33 |
| III. B. Division of Vocation Rehabilitation (DVR) and Department of Services for the Blind (DSB) | 37 |
| III. C. Social Security Administration (SSA) Programs | 45 |
| III. D. Workers' Compensation Insurance—Department of Labor & Industries (L&I) | 47 |
| Chapter III Notes | 50 |
| CHAPTER IV | |
| EDUCATION-RELATED SOURCES OF ASSISTIVE TECHNOLOGY FUNDING | 51 |
| IV. A. Primary and Secondary Public School | 51 |
| IV. B. Private and Parochial Primary and Secondary Schools | 58 |
| IV. C. Post-Secondary Education | 59 |
| Chapter IV Notes | 63 |

| | |
|--|------------|
| CHAPTER V | |
| ASSISTIVE TECHNOLOGY FUNDING FOR SPECIAL POPULATIONS | 65 |
| V. A. Early Intervention Services: Part C of the IDEA | 65 |
| V. B. Persons with Developmental Disabilities | 66 |
| V. C. Veterans | 67 |
| V. D. TRICARE | |
| [formerly Civilian Health & Medical Program of the Uniformed Services (CHAMPUS)] | 69 |
| V. E. Long-Term Residential Care Facilities | 71 |
| Chapter V Notes | 74 |
| CHAPTER VI | |
| WHAT TO DO WHEN ASSISTIVE TECHNOLOGY FUNDING IS DENIED: | |
| AVENUES OF APPEAL | 75 |
| VI. A. Health-Related Sources of Funding | 75 |
| VI. B. Employment-Related Sources of AT Funding | 82 |
| VI. C. Education-Related Sources of AT Funding | 85 |
| VI. D. Special Populations | 87 |
| Chapter VI Notes | 90 |
| CHAPTER VII | |
| ALTERNATIVE SOURCES OF ASSISTIVE TECHNOLOGY FUNDING AND | |
| TAX INCENTIVES | 91 |
| VII. A. Private Bank Loans | 91 |
| VII. B. Community Service Organizations | 91 |
| VII. C. Used and Recycled Equipment | 91 |
| VII. D. Private Trusts and Foundations | 92 |
| VII. E. Income and Business Tax Incentives | 92 |
| APPENDIX 1 — RESOURCES | 95 |
| APPENDIX 2 — SAMPLE LETTER OF JUSTIFICATION | 101 |

ABOUT THIS MANUAL

This manual was prepared by the University of Washington Center for Technology and Disability. The funding was provided by the Washington Assistive Technology Alliance (WATA), a federally funded project whose goal is to increase access to assistive technology (AT) for people with disabilities of all ages in Washington state.

The purpose of this manual is to give consumers and their advocates sufficient information and guidance to pursue appropriate avenues for funding, to provide helpful hints to make the process more likely to be successful, and to provide resources for additional information. We have not attempted to answer every question concerning AT funding but rather to provide sufficient information for the consumer or consumer advocate to successfully advocate for AT in each of the systems addressed. The information contained in the manual is not intended to be a substitute for legal advice; the manual is written generally and will not necessarily address each consumer's individual needs. We focus on obtaining AT funding under the major funding sources for AT. It is not possible to provide an exhaustive description of the rules and regulations for all funding sources because available sources and their specific rules regarding AT purchase are continually changing. We will attempt to keep this manual current, but inevitably you may find some outdated information here. If you would like the latest updates, additional information on a specific funding issue or clarification on something in the manual, please contact the AT Resource Center. Our staff is available to help consumers get the AT they need. We welcome inquiries by letter, phone or email.

The University of Washington Center for Technology and Disability
800-841-8345 V/TTY (toll free)
206-685-4181 V/TTY
206-616-1396 TTY
uwat@u.washington.edu (email)
<http://wata.org> (on the Web)

In addition to answering individual questions or concerns, we are particularly interested in identifying, and eliminating, barriers to obtaining AT in Washington state. We hope that consumers and their advocates will contact us immediately if they are aware of a denial of funding for a device or related service or other rights to AT. We use information on funding denials and other barriers to identify needed changes in laws, policies and practices with the goal of making AT more readily available to people who need it. The information provided by consumers of AT is vital to that process.

This manual or any portions of it may be freely reproduced and distributed if acknowledgment is given to WATA. These publications also are available from WATA's Web site and, to the extent possible, we urge you to take advantage of that resource. This manual and all WATA publications are available in alternative formats on request.

CHAPTER I

ASSISTIVE TECHNOLOGY BASICS

I. A. INTRODUCTION

Many consumers are not able benefit from assistive technology (AT) because they do not have the means to pay for and don't know how to obtain funding for AT services and devices. It is the goal of this manual to assist the consumer or consumer advocate in finding a source to pay for AT.

Although there are many different sources of funding for AT, surveys indicate that personal resources are still the single most important source—accounting for approximately 39 % of purchases in a 1996 survey of AT users in 14 states.¹ Other significant funding sources (roughly in order of importance) include Medicaid (20%), Vocational Rehabilitation (19%), private medical insurance (17%), Medicare (15%), family and friends (14%), schools (12%); Social Security Insurance (SSI) (12%); loans (7%); Social Security Disability Insurance (SSDI) (6%); Military & CHAMPUS (Civilian Department of Defense employees) (2%) and “other” (14%).²

LEGISLATIVE HISTORY OF AT

In 1980, the United States Senate Committee on Labor and Human Resources commissioned an investigative study into the role of technology in the lives of people with disabilities. As a consequence of this study and in recognition of the increasing importance of technology in the lives of people with disabilities and the difficulty individuals have obtaining it, Congress passed the Technology Related Assistance for Individuals with Disabilities Act (Tech Act) in 1988 as amended. Funding was authorized through the National Institute on Disability and Rehabilitation Research (NIDRR) establishing projects in each state to implement changes in laws and policies, develop information resources, and provide legal advocacy services with the long-range goal of creating permanent mechanisms to provide and fund AT. The Tech Act legislation expired in 1998 and was replaced with the Assistive Technology Act of 1998 which continues the state projects at a reduced funding level until 2004.

The AT project in Washington state was funded in 1993 and is administered by the Division of Vocational Rehabilitation (DVR). The project subcontracts with the University of Washington Center for Technology and Disability to develop professional training, coordinate legislative and policy change, and provide consumer advocacy services. The project also contracts with Easter Seal Society in Spokane to manage a statewide information and referral system. Additionally, federal funding is provided to Washington Protection & Advocacy System (WPAS) through NIDRR for legal advocacy and representation on AT issues. These organizations are partners in the Washington Assistive Technology Alliance (WATA).

DEFINITION OF AT

Under the law, AT is defined as including both assistive devices and the services needed to make meaningful use of such devices. The Tech Act defines an *assistive technology device* as:

any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.³

Assistive technology service is defined as:

any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. The term includes:

- a) the evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in the individual's customary environment;
- b) purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
- c) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing of assistive technology devices;
- d) coordinating and using other therapies, interventions or services with assistive technology devices such as those associated with existing education and rehabilitation plans, and programs;
- e) training or technical assistance for an individual with disabilities or, where appropriate, the family members, guardians, advocates or authorized representatives of such an individual;
- f) training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other individuals who provide services to, employ or are otherwise substantially involved in the major life functions of individuals with disabilities.⁴

These definitions have been widely adopted and are now found in a number of other state and federal statutes including the Individuals with Disabilities Education Act (IDEA), the Rehabilitation Act of 1973, and the Developmental Disabilities Assistance and Bill of Rights Act.

The AT definition is comprehensive and covers a vast range of devices and services. AT can be light tech or high tech. It can be purchased off the shelf from the local hardware store or it can be designed especially for people with disabilities and marketed through catalogues or specialty stores. Examples include oil filter wrenches used to open Mason jars, Velcro, adapted clothing and toys, computers, seating systems, power wheelchairs or scooters, communication devices, special switches, assistive-listening devices, hearing aids, magnification systems, visual aids, memory prosthetics (i.e., use of a pager with pre-scheduled messages as a reminder for taking medication or appointments) and many other items used to assist people with disabilities with daily living tasks, communication, education, work and recreation.

In addition to devices, the term assistive technology also refers to related services. Such services include assessments, trial usage, training, maintenance and repair of equipment. AT assessments are used to identify the particular devices—if any—that would be helpful to an individual with a disability, based upon the evaluator's assessment of the individual's functional strengths and abilities, the consumer's goals and preferences, and information about where and how the AT will be used.⁵ A proper AT assessment also addresses the related services needed to support use of the device. Assessments and other services are critical to the successful selection, acquisition and use of appropriate AT.

In this manual we only address the topics directly related to funding for AT. However, successful acquisition of appropriate AT involves much more than getting a device or service funded. Paying careful attention to the process of selection of assistive devices assures that the devices purchased meet the needs of their users. Although some devices serve their purpose for a period of time and are no longer needed because of changes in their owner's situation, many devices are never used because: (a) the person choosing the device does not consider whether it is something that the consumer wants and will use in his or her regular environment; (b) the device does not work as anticipated or is not reliable; (c) the device is too complicated or difficult to use; or (d) the user or the user's family, teacher or health care provider does not receive adequate training (or other needed support services) to make meaningful use of the device.

To maximize the chances that the AT you select will benefit you, WATA encourages you to do the research necessary to identify the appropriate AT. The chances for finding AT funding are vastly improved if there is supporting documentation to show the relevance of the AT you want to be funded. Part I. B. discusses basic strategies for obtaining AT funding and the first step involves choosing appropriate technology.

I. B. BASIC FUNDING STRATEGIES

Obtaining funding for AT from almost any source takes time and effort. The more expensive the item, the more time and effort will generally be required. If you are eligible for more than one funding source, you should think about pursuing those sources at the same time. Many sources require that you exhaust other resources before they will fund a device but you may be able to persuade these sources to collaborate in funding the device and related services. The steps we outline below are generally applicable wherever you are seeking funding.

STEP ONE: RESEARCH AT OPTIONS

The first step in the successful acquisition of AT is to become generally familiar with what AT exists and may be helpful. There are many sources of information about AT. You may obtain information by contacting WATA's information and referral line, participating in WATA's online AT forum, or visiting the ATRC Web site (Appendix 1). Other information sources include: your doctor, rehabilitation counselor, occupational therapist, physical therapist, speech language therapist or other health care professional; local vendors of medical equipment (check the yellow pages) some of which have catalogues or showrooms; and disability-related organizations such as

Easter Seals, the United Cerebral Palsy Association, and the Community Service Center for the Deaf and Hard of Hearing and Community Services for the Blind and Partially Sighted.

One of the most comprehensive sources of information is ABLEDATA. ABLEDATA is a national database of information on AT and rehabilitation equipment. ABLEDATA's contact information is available in Appendix 1. You also may want to contact manufacturers or distributors directly. Many manufacturers have catalogues that show and describe their products. A number of manufacturers also have local distributors who will demonstrate their products.

Your goal in obtaining information about AT is not necessarily to become an "expert" but simply to learn about the options available. The more you know about AT, the more effective you can be as a consumer or consumer-advocate. Consider the following points when choosing AT:

What Will Work for the User?

No device is right for everyone. People with the same functional limitations may need different devices depending upon who they are, what they do and where they live. Does the consumer have more than one functional limitation to be considered? What type of support for use of the device will the consumer have in the family, at work, at school or in the community environment? Will the device need to be moved from location to location? Portability is often an important consideration. How effective and reliable is the device? Is information available on the costs and frequency of repair? Where will you have to send the device if it needs repair? Most important, what are the consumer's needs and preferences? The National Council on Disability reports that the four most important criteria reported by consumers in choosing AT across disability and type of technology are: effectiveness, affordability, operability and dependability.⁶

High-Tech Devices May Not be Necessary

High-tech devices typically cost more and require more skill and training to use than "light-tech" devices. If the AT is difficult to use, it can lead to frustration, discouragement and abandonment. Start with less expensive and easier-to-use, light-tech devices; then make the transition to more complex devices, if needed and appropriate. To find out what light-tech devices are available, review copies of the many AT catalogues that are now available or check your local hardware, electronics, drug, and kitchen stores, which are wonderful sources of inexpensive technology. Examples of such technology include: programmable thermostats and sensors, automatic lights, emergency alert systems and commonly used kitchen utensils with larger, easier to grip handles, such as adaptive ice cream scoops and pizza cutters.

A Particular Product May Not be the Best

We often get calls from consumers or advocates who have already decided on a particular device—voice-activated computers, for example—which they are convinced will be "the answer" to the functional limitation at issue. Sometimes, they are right. Quite often, however, the particular device identified doesn't work as anticipated or a different type of accommodation

would really work better. Before deciding on a particular device—or any device at all—it is important to obtain a good AT assessment. This is one that considers both technological and non-technological solutions. The goal of an AT assessment is to find ways to assist people in performing everyday activities, with or without technology. Before you make up your mind that a particular device is “the solution,” take the time to get an AT assessment and to consider possible alternatives—it will help with your funding efforts.

STEP TWO: OBTAIN AN AT ASSESSMENT

In an AT assessment, an experienced professional evaluates a consumer's functional capabilities and determines which—if any—AT options will work best for the consumer considering the his or her preferences and the environment in which the AT will be used. In most cases, the AT assessment is essential for two reasons: (1) it will increase the likelihood of a good fit between the individual and the AT purchased and (2) it will help in proving to funding sources the need for AT. A good AT assessment also will consider the extent to which AT is *really* needed and/or whether other non-AT solutions may be equally or more effective.

A growing number of options are available and it often takes an experienced professional to know what will work best for you. The professional will prepare a written report that you can use to document your need for a particular device and be source of information for the funding agency, should there be questions.

Assessments should be done by persons with specialized training and expertise in the particular type of AT under consideration. This should be a neutral or independent medical professional, a rehabilitation engineer or someone with expertise in adaptive computer solutions. AT vendors can be good sources of information about products and qualified AT professionals in the community. However, AT vendors cannot provide *independent* AT assessments.

The best assessments offer an opportunity for the consumer to try out the equipment by borrowing or renting it for long enough to determine if it will be effective. If borrowing or renting the device is not possible, try to purchase the item on “approval.”

Remember, you can ask the funding agency or organization to pay for the AT assessment, as well as the device or service. Follow the guidelines set out in Steps 4-11 below when requesting funding for an AT assessment. Be sure to ask what services will be needed to support use of the AT and to request funding for those also. The individual who does the assessment may be able to help you order and install the equipment and assist you with training.

Even if you plan to purchase a piece of equipment with your own money, have an AT assessment to be sure you are getting the type of equipment that is best for you. Ask lots of questions during the assessment and take the time to look at alternatives. WATA can help you identify qualified professionals who can provide AT assessments.

STEP THREE: RESEARCH FUNDING SOURCES

After researching the options for AT and getting an AT assessment, the next step in the successful acquisition of AT is to research funding sources. Identify probable funding sources for both the AT assessment and the AT. Then, contact the appropriate agency or agencies to determine eligibility and criteria for funding of AT. It is likely you can speed up getting your AT if you simultaneously pursue multiple funding options.

STEP FOUR: IDENTIFY ELIGIBILITY CRITERIA, AGENCY POLICIES AND PROCEDURES

Each funding agency has its own eligibility criteria for funding AT. Find out what these criteria are and use them as a framework for writing your funding request. Obtain a written copy, if available, so that you will have a reference for the appropriate language to use in your request. For example, if you are seeking funding for an augmentative communication system through a health insurer, you will need to use words that show the device you are requesting is “medically necessary,” as defined by the insurer. To prove “medical necessity,” describe how the condition affects the individual’s ability to communicate symptoms and discuss medical issues with a health care provider, and to otherwise participate in medical decisions. If you are seeking funding from the Division of Vocational Rehabilitation (DVR), it will not help your case to discuss “medical necessity.” For DVR funding, you should discuss how the inability to communicate affects employability and how the applicant’s job prospects would be improved with the use of an augmentative communication system. The request for funding must address the specific criteria used by that particular funding source. Otherwise, the request will probably be denied.

In addition to specific eligibility criteria, each funding agency has its own policies and procedures. For example, Medicaid and many insurance companies require pre-authorization for the purchase of certain types of medical equipment. Medicare does not require pre-approval for most equipment. Ask for information about the agency’s policies and procedures. Be sure to follow those procedures and carefully complete any required forms.

STEP FIVE: SUPPORTING AND JUSTIFYING THE REQUEST

Most funding agencies require supporting documentation to justify any request for AT. This justification must come from the appropriate health care provider. As a consumer or an advocate, you may find yourself in the position of educating care providers about AT, the relevant funding criteria and the need to address those criteria in the funding request. Many health care providers simply do not have extensive knowledge of AT. For example, many primary care physicians (PCPs) do not know enough about the specifics of augmentative communication systems or power chairs to write an acceptable prescription. If a physician submits a simple prescription for a “power chair” or an “augmentative communication system” to most funding agencies, the request will be denied because it is not specific enough or does not relate to the individual consumer’s needs for the AT.

To satisfy the funding agency, the physician must explain how the AT will help with a particular functional limitation, in a way that meets the funding agency’s criteria. Usually obtaining this

type of information will require a specialist to do an AT assessment. However, in managed care programs, the process of getting the referral to a specialist may take a long time. Some consumers help out by preparing an initial outline or draft of the physician's letter. Recognizing the need to educate PCPs on AT issues and AT funding, the American Medical Association has prepared a helpful publication, *Primary Care for Persons with Disabilities: Access to Assistive Technology/Guidelines for the Use of Assistive Technology*. Chicago: AMA (1996).

The people to whom the initial request is directed (VR counselor, managed care utilization representative, etc.) often are not the ultimate decision-makers. They may be required to route this information to another level of bureaucracy or a utilization review committee. In such cases, the better your written documentation, the more likely you are to have a successful outcome. Any information provided over the phone or verbally may not be formally considered. Good written documentation is especially critical if the AT requested is novel, complex or costly, or if a denial and subsequent appeal is likely.

The significance of the initial letter of justification cannot be over-emphasized. An inadequate letter of justification more than likely will lead to a denial of the request and additional delays. For that reason, it is very important that the initial letter of justification provide all needed information in a way that directly responds to the criteria used by the funding agency. The justification letter must describe the type of AT needed in detail and must individually address the need for each of the related components. Failure to provide this level of detail may result in the denial of a legitimate request and needless delays in the funding process.

The objective of any letter of justification should be to explain why a particular piece of equipment and/or related service is necessary for this particular individual, and why funding of this device is appropriate under that particular agency's guidelines and policies.

A sample justification outline (Appendix 2) is intended as a guide for preparing letters of justification. Rather than simply providing a letter, health care providers or consumers often prepare a packet of documentation materials for the funding agency. Such packets may include: letters of justification; catalogues or brochures describing the equipment; and photos, videos and medical records documenting the individual's medical condition, need for and use of the device. Make sure that the materials are well organized, that all attachments are clearly labeled with your name, the document name and the date, and that you have included all forms required by the funding agency. Also be sure that you have addressed the main topics identified in the sample.

STEP SIX: DON'T FORGET NEEDED AT SUPPORT SERVICES

Don't think of the selection and acquisition of an item of AT as the end of a process; really, it is just the beginning. You should always consider and define what support services will be needed to effectively use an AT device. You also will want to determine how to pay for such services.

AT support services may be needed to set up, fit, configure or program the device. Other service needs include training for the user and his or her family, teacher, or personal assistant; follow-up assessments; repair; maintenance; upgrading; and outcome evaluation.

Support services should be considered during the AT assessment. Ask the assessment professional or team how much training will be needed, whether the device will need to be specially programmed and configured, how much maintenance is involved, what will happen if the device needs to be repaired, etc. If other support services will be needed, identify them and ask what they will cost.

Support services should also be addressed by AT vendors. Ask how much time the vendor is willing to commit to set-up and training on the equipment. Find out what they will do if there is a problem with the AT device. The vendor should be willing to repair or replace the device within a reasonable period of time or give you your money back. Ask if the vendor offers service contracts. If so, find out all the details of how much a service contract costs and exactly what it covers. Ask where you will need to send the AT for repair.

STEP SEVEN: THINK ABOUT ALTERNATIVE PAYMENT ARRANGEMENTS

Purchase of a brand new AT device is not always the best solution. It often makes sense to rent or borrow AT rather than to purchase it. Rental or trial use rather than purchase of equipment should seriously be considered when: an individual's condition is not stable—i.e., his or her functional capabilities are diminishing or increasing; the relevant technology is changing rapidly, and/or it is not clear whether the consumer is going to be able to use the device.

Used equipment is another option to consider, even though it can be difficult to get government agencies and insurance companies to pay for it. The ATRC operates an online database to facilitate exchange, sale, and/or donation of AT devices. Visitors to the database can use it to locate or sell used AT. More information about this resource is found in Chapter VII.

STEP EIGHT: BE PREPARED FOR DELAYS BUT BE PERSISTENT

Unfortunately, the process of obtaining AT can be long, tedious and frustrating. Be prepared for delays, but do not hesitate to follow-up on your request. If you are not getting results with your particular counselor or medical consultant, ask for a new one or talk to the supervisor. If someone tells you that the AT device or service is not covered, ask for a copy of the policy or rule where this is written and get help interpreting the policy if you need it. Also, because no denial is official until it is in writing, you should get written copies of any denial. Be polite and courteous so that you maintain cooperative relationships but do not be afraid to be persistent.

STEP NINE: BE PREPARED TO APPEAL

Do not give up if your request is denied. Try again. Ask the funding agency to put the decision in writing if it has not done so. You can always ask the agency to reconsider and you can always

formally appeal as discussed in Chapter VI. The agency must provide you with information on its appeal procedures.

Find out why your request was denied and specifically address those issues in your request for reconsideration or appeal. Did the agency decide that the device was not medically necessary or not necessary to address a barrier to employment? Was your request rejected because it was not the least costly alternative? Was it rejected because the justification was inadequate? Do not give up if the agency says that the device or service is not covered as a matter of policy. You may be able to get funding as an exception to policy if you can establish that it would be cheaper to provide funding for the device than not to—for example, if lack of the device would lead to further hospitalizations, continued unemployment, additional injury, or worsening of other conditions.

If you are still having difficulties getting the AT after appealing, you may benefit from some additional assistance from AT professionals. WATA staff can provide informal advocacy assistance to consumers who are having problems acquiring AT. If this informal advocacy proves (or is likely to prove) ineffective, the case can be referred to WPAS, or another legal resource for legal representation. Be sure to let WATA know if you are running into roadblocks. Contact information for WPAS is available in Appendix 1.

STEP TEN: OBSERVE ALL DEADLINES

It is very important to observe all agency deadlines. If you do not appeal a decision within the time the agency allows, you may lose your right to do so. In some cases, the allowable time to make an appeal is only 20 days; therefore, you must take prompt action in response to a denial.

CHAPTER I NOTES

¹ RESNA (1996). *Results of 1996 Consumer Survey*.

² Id.

³ 29 United States Code (U.S.C.) §3002 (1999).

⁴ 29 U.S.C. §3002 (4) (1999).

⁵ AT assessments are also commonly referred to as AT evaluations. We will use the term assessment throughout this manual.

⁶ National Council on Disability, *Study on the Financing of Assistive Technology Devices and Services for Individuals with Disabilities: A Report to the President and the Congress of the United States*. Washington, D.C.: National Council on Disability, 1993, pp. 50-52.

CHAPTER II

HEALTH-RELATED SOURCES OF ASSISTIVE TECHNOLOGY FUNDING

Private health insurance, including health maintenance organizations (HMOs) and public health care programs, such as Medicaid and Medicare, often pay for AT. As a general rule, health insurance policies and public health care programs do not specifically mention “assistive technology.” Rather, AT is covered under various other benefit categories including, for example, durable medical equipment (DME), prosthetics and orthotics, appliances, adaptive aids, rehabilitation, occupational therapy, speech therapy, physical therapy and/or home health care services. Depending upon the definitions and exclusions used in a specific program or policy, each of these terms might be interpreted to include different types of AT.

In this chapter, we review the major health-related sources of funding for AT including private insurance, Medicaid and Medicare. Funding of AT needed for medical purposes may also be available from other sources including, for example, private disability insurance, the Division of Vocational Rehabilitation, the Department of Labor & Industries (workers’ compensation) and the Veterans Administration. You can learn more about these funding sources in Chapters III and V.

II. A. PRIVATE HEALTH INSURANCE/HMOS

Private health insurance and HMOs represent an important source of funding for AT, but there are many different types of policies and they all have specific rules and requirements. In order to establish a right to AT under a particular policy, you will need to become familiar with the terms of the policy and the procedures that must be followed to obtain AT. As a general rule, you will be successful in obtaining AT if and only if:

- 1) your particular policy covers AT under some category—e.g., DME, prosthetics and orthotics, rehabilitation services;
- 2) the AT you need falls within one of these categories as defined in the policy;
- 3) you have provided the appropriate documentation and followed all procedures outlined in the policy to establish that the particular AT needed is *medically necessary* as that term is defined in the policy; and
- 4) no exclusions, limitations or funding caps apply.

In some cases, obtaining AT through a private insurer can be easy—your request might even be approved in a single phone call to your case manager. In our experience, however, that is the rare case. More often, the process can be difficult and slow—particularly if the insurer is not familiar with the AT requested. The major steps in the process are outlined below.

STEP ONE: REVIEW THE SUMMARY PLAN DESCRIPTION AND/OR POLICY

The first step in obtaining funding for AT through private health insurance is to obtain and read the summary plan description and/or insurance policy.¹ Generally an insurer will send the summary plan description with initial enrollment information. If you can’t find your copy,

request another one from your employer if you have a group policy or from the insurer if you have an individual policy.

Reading an insurance policy and/or summary plan description can be challenging but it is important to take the time to read the fine print. You should pay particular attention to the parts of the policy that: (a) describe the covered benefits; (b) define the terms used in the policy; (c) identify any exclusions or limitations in coverage, and (d) describe the procedures that must be followed in order to obtain AT.

a) Covered Benefits

The *Schedule of Benefits* or *Covered Benefits* sections will describe the various inpatient and outpatient services covered under the policy.

To find out if the AT you need is covered, and to what extent, you must read the actual policy. Look for terms like DME, corrective appliances, artificial aids, prosthetics and orthotics, rehabilitation services, home health care, speech therapy, occupational therapy, physical therapy, orthopedic appliances, and neurodevelopmental therapies (typically covered only for children under six). Every insurance company issues many different versions of its policies so you must read the specific policy under which you are covered. It may be different from your spouses. Also, do not assume that just because you had coverage for DME last year you will have coverage for DME this year.

b) Definitions

The *definitions* section will contain valuable information about how the company defines key terms such as “DME” or “prosthetic.” Use the language in these definitions to show how the requested AT falls within the relevant category of benefits. If there is no definition, make sure it is noted in the letter of justification that the AT requested typically is covered by third party payors as a DME benefit, or under another relevant category. The definitions section will almost always include a definition of “medical necessity.” Policy definitions of medically necessity vary but typically refer to services/supplies that are:

- Consistent with the symptoms, diagnosis, and treatment of the condition
- Not solely for the convenience of the provider, insurance or caretaker
- The least costly of the alternative levels of service that are adequate and available
- The most appropriate level of service or supply needed for such treatment
- Generally accepted within the medical community
- Not experimental

Each of these factors should be addressed in the letter of justification or request for the device to show that the AT is medically necessary.

c) Exclusions, Limitations and Caps

Once you have determined that your policy potentially covers AT, review the policy for limitations and exclusions. Most policies have a general statement of coverage and a very specific statement of “exclusions.” Exclusions are items that the policy does not cover. For example, some policies specifically exclude certain types of DME, such as electronic devices, power chairs or items that require architectural modifications.

Others policies attempt to set limits on the circumstances under which the insurer will pay for rehabilitation services and/or DME. Some policies, for example, cover DME only for hospital inpatients and/or for sixty days following hospitalization. Others attempt to limit coverage to services and equipment necessary to “restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury or illness.” Such a definition could arguably exclude treatment intended to “maintain” or prevent a deterioration of functional capabilities.

Some policies also limit the total amount the insurer will spend in a year or a lifetime on certain benefits. These limits are also known as caps. Some policies, for example, limit DME coverage to \$5,000 or \$10,000 per year. Many policies also limit coverage to 80 or 85% of the cost of the equipment requested.

d) Procedures

The final thing to look for in reviewing the summary plan description or policy is a description of the procedures that must be followed to obtain AT including AT assessments. Key questions are whether: (a) you need a referral or prescription from your primary physician or primary care provider; (b) pre-authorization or pre-approval is required; and (c) use of selected vendors is required or financially advantageous (e.g., the insurer may pay 80 percent of the cost of services and equipment from a “selected vendor” but only 60 percent of the cost of services and equipment from a vendor that is not part of their network). The consumer or consumer-advocate should check the policy or managed care guide to determine what it says about each of these issues. Failure to follow the insurer’s procedures can mean denial of the equipment and considerable financial expense to you.

STEP TWO: REQUEST AND PARTICIPATE IN AN AT ASSESSMENT

After getting all the information you need from the policy, the next step in the process should be to participate in an AT assessment. You may or may not need to obtain pre-approval from the insurer or managed care provider to get the AT assessment covered under the policy. Sometimes the assessment can be covered under a category of service that does not require pre-approval. In other cases, the insurer will want you to get pre-approval, which may require a referral from your physician explaining why the assessment and the AT is medically necessary and appropriate for you. If you are not sure, ask the customer service office.

STEP THREE: DOCUMENT YOUR REQUEST TO THE INSURER

Once you have a qualified AT assessment that has identified the appropriate AT, the next step is to prepare the written documentation supporting the AT request. The documentation should establish medical necessity using a written assessment from an appropriate medical professional. It also should specifically address the relevant policy language identified in your policy, such as why this equipment is the least costly alternative, why the device is not experimental and why it is not solely for the convenience of the caretaker. Point out why the technology is cost-effective—i.e., why it may reduce or limit the insurer's costs for other covered expenses such as personal care or hospitalization. It is also important to provide a basic explanation of the device and what it will accomplish. Include a brochure describing the device if you have one. Pictures of the individual using the device or videos can also be effective.

Insurers sometimes claim that a service is educationally necessary or a convenience item but not medically necessary. The fact that an item will be used in school, allow for access to recreational opportunities or make life easier for the user does not necessarily mean it is not medically necessary. The best strategy in writing the justification letter is to focus on the medical necessity issue—it is what insurers will be looking for to support your AT request.

The question often arises as to who should prepare such documentation. Ideally, the letter should come from the occupational therapist, physical therapist, speech language pathologist or other professional who conducted the assessment. You also will need a letter from your physician. Many physicians are too busy to write detailed letters of justification and you may need to take the lead in drafting a letter in such circumstances or get some help from an advocate. Additional information about justifying your request can be found in Chapter I.

STEP FOUR: DEAL WITH BARRIERS

You are likely to encounter some common barriers as part of this process of obtaining insurance funding of AT. For example, as you start the process, you may be told over the phone that the item requested is simply not covered. Never accept a verbal “no coverage” opinion from the insurer's claims or customer service department. Ask the representative who tells you there is no coverage where that is written in the policy.

If and when you do receive a written denial, call and ask for clarification. Write down what you are told, date it and keep it in a safe place. Find out the deadlines and procedures to appeal. Denials are often overturned on appeal. More information about appeals is provided in Chapter VI.

If your policy does not cover DME or any of the other categories of benefits that might be interpreted to include AT, don't give up. You may be able to get your AT covered in other ways. For example, Washington state insurance regulations require some insurers that cover hospitalization to pay for DME and other services, as a less costly alternative to hospitalization, when prescribed as part of a home health care plan approved by the doctor.² You also may be able to convince the insurer to pay for the device as an exception to policy if you can show that it

would be cost-effective to do so. For example, if the policy covers home nursing care or visits, and the AT would allow the insurer to limit such visits, then the insurer may decide that, over the long run, it makes sense to cover the device.

If you run into these or other barriers, you should also begin to consider and pursue other appropriate funding sources including Medicaid, Medicare, Washington's High Risk Pool and other non-medical options. And remember that WATA staff are available to help whenever you encounter such barriers.

II. B. PUBLIC EMPLOYEES HEALTH INSURANCE

For the most part, if you are a public employee you will need to follow the same general guidelines outlined above for private health insurance. In Washington state, all state employees have the option of selecting policies that include coverage for rehabilitation services, DME, prosthetics and orthotics. However, state employees are not required to purchase such coverage. State employees should review their policies for specific policy language to determine the extent and nature of coverage provided.

There is no requirement that federal employee benefit plans include coverage for rehabilitation services or DME. Although some do, many policies are limited to in-hospital access and a few months' rental following hospitalization. In such cases, the consumer will need to convince the insurer that an investment in AT will be cost effective by avoiding other covered expenditures—such as hospitalization. More information is available through the U.S. Office of Personnel's Federal Employees Health Benefits Program Web site (Appendix 1).

II. C. MEDICAID

Medicaid is a health care program for low-income families that is jointly funded by the state of Washington and the federal government. In Washington state, Medicaid is administered by the Medical Assistance Administration (MAA) which is part of the Department of Social & Health Services (DSHS).

To be eligible for Medicaid, family resources and income must be limited. However, there are many different ways to qualify for Medicaid, including, automatic coverage if you are receiving Social Security Insurance (SSI) and automatic coverage for children living in families (up to 200% of the Federal Poverty Level) enrolled in the Basic Health Plan. There are also special rules for children with developmental disabilities (in which MAA uses the child's income rather than family income to determine eligibility). Determining Medicaid eligibility can be complicated and is beyond the scope of this manual. To find out if you are eligible, contact the closest Community Service Office (CSO). Contact information is available under MAA in Appendix 1.

Most, but not all, Medicaid recipients in Washington state receive their care through Healthy Options, which is a managed care program. Medicaid also covers some recipients (those with special health care needs and recipients living in counties with no contracted managed care

providers) on a traditional fee-for-service basis. In either case, your rights to AT should be the same—although the procedures and decision-makers may be different.

To obtain AT through Medicaid, you will need to establish that (a) the AT requested is included within the scope of covered benefits; (b) the item sought is medically necessary—it is the least costly means of achieving the ends sought, and (c) the proper procedures—including prior authorization from Medicaid—have been followed. Each of these is discussed below.

a) Scope of Coverage

Medicaid does not include specific coverage for AT. Rather, as is the case with private health insurance, the consumer must establish coverage under another category of benefits. The benefit categories provided by Washington Medicaid are defined in the plans which the state submits to the federal government to receive federal matching funds. Most AT is funded by Medicaid as DME. However, funding for AT also may be available in connection with the following categories of benefits:

- Home health care for persons eligible for skilled-nursing services (COPES)
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under the age of 21
- Coverage for eyeglasses and examinations
- Coverage for hearing aids and examinations
- Physical therapy services
- Prosthetics and orthotics
- Surgical appliances
- Rehabilitation services (occupational and speech therapy)
- School medical services for special education students

The definition of DME is determined by each state. Washington does not have a statutory or regulatory definition of DME. However, Medicaid DME billing instructions define DME as equipment that:

- 1) can withstand repeated use;
- 2) is primarily and customarily used to serve a medical purpose;
- 3) generally is not useful to a person in the absence of illness or injury; and
- 4) is appropriate for use in the client's place of residence.

This definition does not carry great legal weight because it is not found in statute or regulation; therefore, the definition should not be used as a basis for denying coverage of equipment including such as scooters that may not be “appropriate” for use in the home.

States may establish reasonable standards for determining the extent of coverage of DME and related benefits and may develop lists of pre-approved equipment. However, there must be a process for seeking modifications or exceptions to the list.³ The level and nature of benefits

provided also must meet federal standards, which stress that the primary goal of Medicaid is to provide medical assistance to persons in need and to furnish rehabilitation and other services to help recipients attain or retain capability for independence or self care. Federal standards also require that each benefit offered be sufficient in amount, duration and scope to reasonably achieve its purpose.

Washington Medicaid's policies with respect to DME and other benefit categories can be found in its regulations⁴ and in its multi-volume billing instructions, which are available at MAA's Web site (Appendix 1). The regulations and the billing instructions describe the types of equipment covered by Medicaid and the criteria for coverage. They also identify certain items as being "non-covered" items (e.g., air conditioners). However, if Medicaid denies a request for funding of medically necessary AT on the grounds that the item is not covered, don't give up. It may be possible to challenge MAA's policy and obtain the equipment through an exception to policy.

b) Establishing Medical Necessity and Least Costly Means

Payment for a requested item will be authorized by Medicaid only when the consumer establishes medical necessity, which is defined as:

[D]escribing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is *no other equally effective, more conservative, substantially less costly course of treatment available or suitable for the client requesting the service*. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.⁵

Basically, you must show that the AT service or device is needed to prevent, alleviate or correct a condition, or to minimize or alleviate suffering. Other successful arguments include evidence that the AT:

- Prevents further injury or pain
- Prevents secondary complications
- Is necessary for communicating symptoms
- Is needed for safety reasons
- Prevents deterioration in mental health
- Decreases dependence on other services and devices
- Serves as a prosthetic bridge of lost functional capacity
- Is required as part of a physical therapy, occupational therapy or speech therapy program

Washington's definition of medical necessity also requires Medicaid recipients to establish that there is *no other equally effective, more conservative, substantially less costly course of treatment available* to meet the consumer's needs. For example, if you request a wheelchair that is more

expensive than most, your request for coverage should explain why a less costly wheelchair does not meet your medical needs. To satisfy the least costly requirement, you will need to prove three things: 1) that the features of the specific AT are medically necessary; 2) that the features are not included in the less costly alternative AT, and 3) that the features are included in the AT you requested.

It is almost always essential that you submit an AT assessment from a qualified—and neutral—AT professional to establish medical necessity. Most requests for AT funding through Medicaid are submitted directly to MAA by authorized equipment vendors. Vendors in Washington are usually well versed in Medicaid rules and criteria and you may be tempted to rely solely upon their judgment. However, MAA is likely to be skeptical of any request that comes only from a vendor without an accompanying evaluation or letter of justification from an independent AT or medical professional.

c) Getting Prior Authorization and Funding Justification

To obtain funding for DME through Medicaid, you need to work with a Medicaid-authorized vendor. In most cases, you will need to obtain pre-authorization. This means that you need to get pre-approval before the device is purchased. If the recipient is in Healthy Options, the request for pre-approval should be made to the managed care provider. If the recipient receives services on a fee-for-service basis, the request is made directly to MAA. Although pre-approval takes a little extra time, it allows both the vendor and the consumer to know whether Medicaid will pay for a device before it is actually purchased. If the requested device or service is needed on an emergency basis—repair of a power wheelchair, for example—the initial request can be made over the phone.

Your doctor or medical provider normally must submit a written request (usually through the vendor) with documentation of your need for the requested services or device to get prior authorization. This documentation—or funding justification—must explain why the requested device is necessary to increase the recipient's independence, safety, functional abilities, or to alleviate the impact of disability. It also should detail what other less costly alternatives were considered and rejected and the reasons they were rejected. When approved, DME and prosthetic devices are reimbursed using a fee schedule outlined in MAA's Billing Instructions. Medical equipment can also be rented in some cases. Equipment vendors are required to accept the payment offered by Medicaid—even if it is less than the price they might get from other third-party payors. By law, vendors are prohibited from asking Medicaid recipients to pay any part of the cost of a covered item.

Medicaid has 15 days from the time a request is submitted to approve or deny it. If Medicaid denies the request, the denial must include an explanation of why authorization was denied and information about appeal rights. More detail on appealing Medicaid decisions can be found in Chapter VI.

THE EPSDT PROGRAM—HEALTHY KIDS

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a mandatory federal Medicaid service imposed on the states as a condition of receiving federal Medicaid money.⁶ In Washington state, the EPSDT program is known as Healthy Kids. Children birth through age 19 are eligible for this program if they are residents of the state with incomes below 200% of the Federal Poverty Level or legal immigrants. In addition, undocumented children from birth through age 18 are eligible at 100% of the Federal Poverty Level.⁷ There are two parts to EPSDT: 1) screening services (including periodic medical exams such as well-baby visits and special screenings)⁸ and 2) any treatment or services prescribed by a physician that are included in the federal Medicaid program. EPSDT, like all Medicaid programs, covers both medical assistance and rehabilitation and other services to help “attain or retain capability for independence or self-care.”⁹

Under EPSDT, eligible children are not limited to the specific Medicaid benefits offered to adults. Children eligible for Healthy Kids are entitled to broad coverage including any “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.”¹⁰ These services may include AT that would ordinarily not be provided to an adult Medicaid recipient. As such, advocates for children seeking AT from Medicaid may point to EPSDT as a basis for covering any medically necessary AT—whether or not that AT is listed as covered in MAA regulations or billing instructions.

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)

The Community Options Program Entry System (COPES) is a special community-based program available through Medicaid for individuals 18 and over who otherwise qualify for placement in a nursing facility or other institutional care. The goal of the program is to offer individuals a choice of either institutional or home and community-based services. Individuals who qualify for COPES are eligible to receive a range of services above and beyond those ordinarily funded under Medicaid including: extended skilled nursing and home health aide services; environmental modifications to the client's home as needed to ensure the client's health and safety or ability to function independently; personal emergency response systems, and funding for transportation above and beyond that normally provided by MAA through its brokered transportation services. Under COPES, case managers have significant flexibility to fund a wide range of services (and equipment) as needed to achieve the program's objectives of keeping COPES' recipients in the community and out of institutional settings. Adults with significant health conditions may find that the COPES program offers them expanded opportunities for access to Medicaid-funded AT and related services.

II. D. MEDICARE

Medicare is a federally funded national health insurance program for people 65 years of age and older and certain groups of younger people with disabilities. People receiving Medicare are known

as beneficiaries. Medicare is administered by the Health Care Financing Administration (HCFA), a federal agency within the Department of Health and Human Services. HCFA makes rules governing the provision of services—including medical equipment—under Medicare.

Eligibility for Medicare is not based on an individual's financial status. It is a health insurance program funded through employer and employee payroll taxes. To be eligible for Medicare, you must be over 65 or you must have been on Social Security Disability Insurance (SSDI) for 24 months. The disabled adult child of a Medicare beneficiary, or deceased Medicare beneficiary, is also eligible to receive Medicare benefits. Some individuals who are low income and disabled qualify for both Medicaid and Medicare. If you are not sure of your eligibility status for Medicare benefits, you can inquire about it at your local Social Security office. Questions concerning benefits can be directed there as well.

Medicare benefits are divided into Parts A and B. Each has different administration, service scope, authorization and appeals procedures. Hospital Insurance (Part A) covers care in hospitals, skilled nursing facilities and some home health care services. Part A does not require that the beneficiary pay a premium. Part A pays for some DME, such as wheelchairs and hospital beds, under the home health care benefit. Part A will also cover physical therapy, speech-language therapy, and occupational therapy under certain conditions. However, most AT is covered under Part B (Medical Insurance).

To be eligible for Part B, beneficiaries pay a monthly premium. Part B covers outpatient hospital care, physician services, and other medical services like physical therapy, medical transportation, DME and prosthetic devices. The following discussion focuses on Part B which is the major funding source under Medicare for AT devices and services. For more information about either Parts A or B of Medicare, contact Statewide Health Insurance Benefits Advisors (SHIBA). Contact information is located in Appendix 1.

Certain standards and procedures must be satisfied in order to obtain AT through Medicare: (a) the requested AT must fall within the scope of benefits funded by Medicare; (b) the AT must be "reasonable and necessary," and (c) Medicare's authorization procedures must be meticulously followed. Each of these elements is discussed below.

a) Scope of Coverage of DME and Other Forms of AT

AT is typically funded under Part B of Medicare under one of three categories: durable medical equipment (DME), prosthetics or orthotics.¹¹ Federal regulations define DME as equipment that:

- 1) can withstand repeated use;
- 2) is primarily and customarily used to serve a medical purpose;
- 3) generally is not useful to an individual in the absence of an illness or injury;
- and
- 4) is appropriate for use in the home.¹²

Prosthetics are defined as devices “that replace all or part of an internal body organ.”¹³ The Medicare Carriers Manual refines this definition to include devices that “replace all or part of the *function* of a permanently inoperative or malfunctioning external body member or internal body organ”—meaning that the term “prosthetic” can also include AT that does not physically replace internal organs but does substitute for malfunctioning organs.

Orthotics are defined to include leg, arm, back and neck braces and “orthopedic devices that support or align movable parts of the body, prevent or correct deformities, or improve functioning.”¹⁴ The Medicare Carrier's Manual further explains that a brace is “a rigid or semirigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.” These definitions can be used to argue for Medicare coverage of any AT commonly used to support or add function to movable parts of the body, such as wheelchairs and patient lifts.

Although these definitions are broad, HCFA has provided strict guidelines as to what qualifies as DME (or prosthetics and orthotics) under Part B. These guidelines are published in its Carriers Manual, which lists what devices are and are not covered and outlines more specifically the criteria and requirements for funding of particular types of equipment. HCFA also periodically issues National Coverage Decisions (NCDs) which specify what services and equipment are approved or disapproved for coverage by Medicare.

The Medicare law also specifically excludes several major categories of AT, including eyeglasses and contact lenses (except when associated with cataract surgery), hearing examinations, hearing aids and orthopedic shoes (except when required because of the symptoms of diabetes).¹⁵ Medicare also will not cover AT that can be used for non-medical purposes, even if there is also a medical use for it.

All DME claims under Part B are processed by four regional carriers contracted by HCFA. Washington is in Region D, which is administered by CIGNA located in Nashville, Tennessee. HCFA expects its Medicare carriers to defer to its lists of approved and disapproved AT in making coverage decisions. If an item is on the disapproved list, carriers will not approve its purchase. The only recourse is to appeal. If the requested item does not appear on either an approved or disapproved list, a case for coverage can be made to CIGNA and if that is unsuccessful, an appeal may be filed. Suppliers of DME generally know whether a particular item is on an approved or disapproved list. Initial questions regarding coverage can also be directed to your local Social Security office or to CIGNA (Appendix 1). Information about the Part B Appeal Process can be found in Chapter VI.

b) Proving Medical Necessity

In addition to showing that the AT requested falls within one of Medicare's defined benefit categories, you also will need to show that it is medically necessary—or in Medicare terms, “reasonable and necessary.” Only AT that meets this standard will be paid for by Medicare.¹⁶ Reasonable means that it is the lowest priced item that will meet the medical need of the

beneficiary and that the amount paid is consistent with the amount Medicare has set as the allowed amount for this item. Necessity is established initially by the beneficiary's physician who must complete and submit a "certificate of medical necessity" along with other documentation describing the beneficiary's condition and why the recommended AT is both reasonable and medically necessary. The certificates of medical necessity are provided by HCFA and ask the physician to answer certain questions that reflect HCFA criteria and standards for funding various types of AT. Medical documentation of medical necessity and reasonableness—and a thorough understanding of Medicare's funding criteria—are critical to success in acquiring AT through Medicare.

c) What You Need to Know About Medicare Procedures

With some exceptions, Medicare generally does not require or provide pre-authorization. Under Medicare, vendors are required to purchase the equipment, give it to the customer and then submit a request for reimbursement to CIGNA. CIGNA makes the initial determination of whether Medicare will pay for a particular device and, if so, how much. In processing this claim, the carrier has significant flexibility. It can determine that the item was not a covered item or not medically necessary and deny any reimbursement; it can "downgrade" the request, reimbursing the vendor a lesser amount than his actual outlays on the grounds that a less expensive item would meet the patient's needs; or it can reimburse the vendor on the basis of its standard "allowable" which is often less than the typical retail price of the item purchased. It is possible to change the carrier's determination through an appeal but this can be a long process.

Medicare relies upon lease-purchases, rentals and/or lump-sum payments. Medicare rules establishing which payment option is selected can be complicated. In some cases, the Medicaid carrier decides whether rental or purchase is an option; in others, the beneficiary is allowed to make that choice. If purchase is an option, it is important to know that Medicare "allowables" for equipment purchases tend to be lower than some vendors are willing to accept. Medicare's allowables are not established by brand and model but are based upon categories which can include a range of models, brands and quality of equipment. The vendor is paid the same allowable for all equipment within the category.

Medicare recipients can sometimes be asked to pay a portion of the cost of the equipment. Under Part B, there is an initial deductible of \$100 per year.¹⁷ In addition, you must pay a 20% co-payment for most services and devices. Physicians and other providers, including suppliers of equipment, are allowed to charge more than Medicare will pay for the covered service under some circumstances. However, some vendors will agree to provide services and equipment on an "assignment basis." If physicians or suppliers agree to provide services and equipment on an assignment basis, they agree to accept the allowed amount that Medicare will pay for a service or device as payment in full without making an additional charge. You must pay 20% and Medicare pays 80%, but there will be no additional cost.

If a physician or an AT vendor has not agreed to accept "assignment," and many have not, he or she may charge you the market price and you will have to pay the extra. This amount can be

substantial, especially for expensive items such as custom wheelchairs. It is not uncommon for a Medicare carrier to set the allowed amount at only 40% or 50% of the market value of a custom wheelchair. The discrepancy between the market value and the allowed amount can easily total several thousand dollars. Although you can try to appeal the allowed amount, you would have to purchase the AT first, take the risk and then appeal. Therefore, it is important to know whether your AT vendor has agreed to provide the equipment on an assignment basis. The names, addresses and telephone numbers of physicians who accept assignment in Washington state are available by calling the Part B claims carrier which is Blue Cross/Blue Shield of North Dakota. The names and contact information for DME vendors who accept assignment can be obtained by calling CIGNA. CIGNA's Web site includes a manual for suppliers. However, it does not include a list of approved AT vendors. If you are trying to get DME funding under Part A, the appropriate contact is Premiera Blue Cross of Washington or Regency Blue Shield of Washington. Contact information for Blue Cross, Blue Shield and CIGNA is available in Appendix 1.

Some equipment vendors in Washington are reluctant to accept Medicare clients because of the lack of assurance in funding of medical equipment under Medicare, and the extensive paperwork required. Others may tell you that a particular item is not available through Medicare when, in fact, the equipment could be purchased—but at a financial loss to the vendor. Please feel free to contact WATA staff whenever you encounter such barriers. We will do what we can to assist you in overcoming them.

SPECIAL ISSUES FOR CONSUMERS WHO ARE ELIGIBLE FOR MEDICAID AND MEDICARE

Consumers who are eligible for both Medicaid and Medicare can find themselves in a particularly difficult situation. For most types of medical equipment, Medicaid requires that consumers apply to Medicare before they apply for funding from Medicaid. This is true unless Medicaid knows that Medicare will not pay for the device as a matter of policy (e.g., the device is identified as uncovered on HCFA's list). If you are covered by both Medicaid and Medicare, Medicaid should pay 20 % of the cost that Medicare does not pay. However, Medicaid only pays 20 % of the reasonable rate established by Medicare even though in many instances it is much lower than the amount Medicaid would otherwise pay for a particular item of equipment. Vendors are likely to be reimbursed at a higher rate if the client is only Medicaid. Thus, vendors may be reluctant to serve clients who are dually eligible or reluctant to recommend specialized equipment. If you or someone you know runs into this situation, please feel free to contact WATA.

II. E. CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Congress passed the Children's Health Insurance Program (CHIP) legislation in 1997. The program provides federal funding for new state CHIPs with the goal of reducing the number of uninsured children in this country. The Washington legislature approved a state CHIP program during the 1999 session and is now eligible to receive federal funds to subsidize health insurance for children living in families with incomes that are between 200-250% of the Federal Poverty Level. Although the program has not been developed as of the publication of this manual, it is anticipated that an additional 10,000 uninsured children in Washington will be covered, with

enrollment expected to begin in January 2000. Because MAA has the responsibility to create a Medicaid-like program, DME, prosthetics and orthotics, and related services will likely be covered. For more information on the specifics of CHIP coverage, contact the MAA (Appendix 1). You can also obtain current information from the Children's Alliance (Appendix 1).

II. F. WASHINGTON STATE BASIC HEALTH CARE PLANS

The Washington Basic Health Plan (BHP) is a state-funded insurance program for low and middle income adults and children. The BHP provides subsidized basic health insurance for individuals and families up to 200% of Federal Poverty Level. Families above 200% of the Federal Poverty Level may also enroll but will pay the full premium.

BHP services are provided through contracts with health care providers. Children living in families with incomes less than 200% of the federal poverty guidelines are automatically enrolled in Medicaid and receive DME and other services through Basic Health Plus, a program jointly administered by the Washington State Health Care Authority (HCA) and DSHS. However, the BHP does not currently cover rehabilitation services, prosthetics or DME for adults; nor does it provide coverage for vision, hearing or dental devices or services. Legislation to add rehabilitation services to the BHP has been introduced in the state legislature numerous times without success.

Although adults insured under the BHP generally do not have access to coverage for DME, they can always request such equipment as an "exception to policy"—substantiating the request with evidence that purchase or rental of the equipment is less costly than some other form of covered treatment and/or that the equipment is necessary to prevent accidents, deterioration or hospitalization, which would be covered by the BHP. Probably you will first need to appeal an adverse decision and ask your PCP's help in documenting that coverage of the equipment will be cost-effective for the managed care plan. WATA is very interested in hearing from BHP enrollees who need but are denied coverage for DME through the Plan.

II. G. WASHINGTON STATE'S HIGH RISK POOL

Washington residents who have difficulty qualifying for private health insurance or who find that their current coverage is inadequate may want to explore eligibility under the Washington State Health Insurance Pool (WSHIP). WSHIP, the state's high-risk pool, was created in 1987 for people who are unable to obtain comprehensive health insurance coverage for any reason. Most of the several hundred people covered by the pool today are seniors unable to purchase Medicare Supplement policies. The pool is open to any resident of the state who is rejected for coverage by another insurer for medical reasons or who has inadequate coverage because of the effects of restrictive riders or limitations on coverage of pre-existing conditions. The pool covers reasonable and necessary medical services and devices required by physician's orders and consistent with the patient's diagnosis, treatment and condition.¹⁸ Web sites with more information are listed in Appendix 1.

CHAPTER II NOTES

¹ The summary plan description and[-/or-] insurance policy are not necessarily the same thing, although they should not contradict each other.

² Washington Administrative Code (WAC) 284-46-500(Health Maintenance Organizations); WAC 284-44-500 (Health Care Services Contractors); WAC 284-50-330(Individual policies); WAC 284-96-500(Group policies).

³ HCFA policy directive, dated September 4, 1998 and *DeSario v. Thomas*, 139 F.3d 80 (2nd Cir. 1998); cert granted, judgment vacated by *Slekis v. Thomas*, 119 S.Ct. 864 (1999).

⁴ The rules that govern Medicaid funding of durable medical equipment, prosthetics and orthotics can be found in Chapter 388 of the Washington Administrative Code—particularly WAC 388-86, WAC 388-87 and WAC 388-500 and WAC 388-501. One of the most important regulations is WAC 388-501-0165 which describes the basic guidelines that govern Medical Assistance Administration decision-making on requests for coverage of medical services including durable medical equipment.

⁵ WAC 388-500-0005.

⁶ 42 United States Code (U.S.C.) § 1396d(a)(4)(B).

⁷ The Federal Poverty Level changes each year. For 1999, the monthly FPL for a family of four was 1392 (100% FPL). HHS Web site <http://aspe.hhs.gov/poverty/99poverty.htm>.

⁸ 42 U.S.C. § 1396d(r)(1)(A).

⁹ 42 U.S.C §§ 1396d(r)(1)-(5).

¹⁰ 42 U.S.C § 1396d(r)(5).

¹¹ 42 Code of Federal Regulations (C.F.R.) § 414.210.

¹² 42 C.F.R. § 414.202.

¹³ Id.

¹⁴ 42 C.F.R. § 410.36(a)(3), 42 C.F.R. § 410.100(g).

¹⁵ 42 U.S.C. § 1395y(a)(7)(8).

¹⁶ 42 U.S.C. § 1395y(a)(1)(A).

¹⁷ This amount is satisfied only by the recipient paying charges that Medicare would allow, which may be less than the full amount of the bill.

¹⁸ Revised Code of Washington (RCW) 48.41.110.

CHAPTER III

EMPLOYMENT-RELATED SOURCES OF ASSISTIVE TECHNOLOGY FUNDING

This chapter describes funding options for individuals who need AT for work or to prepare for employment. The first section provides an overview of the rights of people with disabilities to have AT provided by an employer under federal and Washington state law. The remainder of this chapter reviews other major sources of funding for work-related AT. These sources include vocational rehabilitation services; return-to-work incentive programs for recipients of Social Security Insurance (SSI) and Social Security Disability Insurance (SSDI), and workers' compensation insurance. Information on applicable tax deductions for work-related AT is found in Chapter VII. Funding on work-related AT for veterans is discussed in Chapter V.

III. A. EMPLOYERS

Various federal and state laws prohibit employers from discriminating against qualified employees or job applicants with disabilities. These laws also require employers to provide people with disabilities with reasonable accommodations (including AT) as needed to perform the essential functions of the job. The primary laws relevant to funding of AT are the Americans with Disabilities Act (ADA),¹ the Rehabilitation Act of 1973,² and the Washington State Law Against Discrimination (RCW 49.60).³

The Rehabilitation Act of 1973 was the first federal statute to prohibit discrimination in employment against persons with disabilities. This Act applies to federal employers (Section 501), federal contractors (Section 503) and recipients of federal financial assistance (Section 504). The ADA was passed in 1990 and is a broad civil rights statute. The law guarantees people with disabilities access to employment (Title I), public accommodations (Title III), state and local public services (Title II), transportation (Titles II and III) and telecommunications (Title IV). The ADA prohibits discrimination in employment by state and local governments and private employers with 15 or more employees. The Washington State Law Against Discrimination (RCW 49.60), makes it unlawful for employers with eight or more employees to discriminate against persons with sensory, mental or physical disabilities in employment as well as public housing, insurance, and education.

Each of these laws covers certain types of employers but does not necessarily apply to all employers. It is beyond the scope of this manual to go into the specifics of who is protected as the manual is intended to provide general funding guidelines only. If you have any question as to whether these laws apply to you or your employer, you should seek legal advice. For purposes of this discussion, we assume that you are a "person with a disability" protected by one or more of these laws. More information about these laws is available at the Web sites of the Job Accommodation Network, ADA Document Center, ABA Commission on Mental and Physical Disability Law, and Equal Employment Opportunity Commission (EEOC) (Appendix 1).

EMPLOYER'S DUTY TO PROVIDE REASONABLE ACCOMMODATION

Under both state and federal law, employers are prohibited from discriminating against employees and job applicants in application procedures, hiring, firing, advancement, compensation, and training as well as other terms and conditions of employment. In addition to prohibitions against outright discrimination, these laws impose upon the employer a duty of reasonable accommodation. For many individuals who need AT to do their job, their employer or prospective employer may be obligated to pay for AT devices as part of this duty of reasonable accommodation. Refusing to provide a reasonable accommodation—including AT—in any aspect of employment may be a form of discrimination.

Reasonable accommodations involve “reasonable” changes in the work environment which make it possible for a qualified person with a disability to perform the essential functions of the job and/or to enjoy other benefits of employment. Employers are not required to undertake accommodations if doing so would constitute an undue hardship—if the accommodation would be too costly or difficult to achieve. There is no hard and fast rule for determining when an accommodation would be an undue hardship; rather that determination is made on a case by case basis looking at all of the facts and circumstances including, for example, the nature and cost of the accommodation; the employer’s financial resources, the number of employees, and the impact of the accommodation on employer operations. Studies show that most accommodations actually involve little or no expense on the part of the employer.⁴

AT is often provided on the job as a reasonable accommodation. Federal regulations state that a reasonable accommodation may include, among other modifications, the “acquisition or modification of equipment or devices” to enable an individual to perform his or her job.⁵ The regulations relevant to private employers do not spell out what types of AT must be provided. Each situation needs to be considered independently to determine the employee’s AT needs and the obligation of the employer to provide such AT. However, some guidance can be found in the regulations that describe the obligations of state and local governments to provide “auxiliary aids and services” for effective communication to employees, applicants and consumers. Such aids and services include:

- Methods of making aurally delivered materials available to individuals with hearing impairments, such as:
 - * Telephone handset amplifiers
 - * Assistive listening devices
 - * Assistive listening systems
 - * Telephones compatible with hearing aids
 - * Closed caption decoders
 - * Open and closed captioning
 - * Telecommunications devices for deaf persons (TDDs)
 - * Video text displays

- Methods of making visually delivered materials available to individuals with visual impairments, such as:
 - * Taped texts
 - * Audio recordings
 - * Brailled materials
 - * Large print materials
- Acquisition or modification of equipment or devices
- Other similar services and actions

Similarly, regulations applicable to employers who receive federal financial assistance specify that employees shall not be discriminated against due to the absence of “auxiliary aids for participants with impaired sensory, manual or speaking skills.” Auxiliary aids include Brailled and taped materials, equipment to make orally delivered information available for persons who are deaf or hard of hearing, equipment adapted for use by persons with manual impairments, and other similar services and actions. The Rehabilitation Act also requires that programs that receive federal financial assistance take appropriate steps to ensure that communications with applicants, employees, and beneficiaries are available to people with impaired vision and hearing.⁶ This may include telephones, TDDs, or equally effective telecommunications systems.⁷

These regulations provide good examples of AT that might be provided by a private employer as a reasonable accommodation. Many other common—and innovative—forms of AT are provided by employers throughout the United States to accommodate the needs of employees with disabilities. Examples include:

- Creation of wheel-chair accessible work stations
- Purchase of adaptive computer hardware, software and peripherals for individuals who have limited mobility, learning disabilities or sensory impairments
- Modifications of company vehicles to accommodate individuals with mobility limitations
- Use of pagers and cell phones to provide job coaching and other assistance to employees with cognitive issues
- Use of specially designed (and often low cost) devices or adaptations which enable employees with functional limitations to effectively use standard office equipment such as copiers, fax machines and telephone equipment

Indeed, the possibilities are almost limitless.⁸

CHOOSING THE RIGHT AT AND ASKING YOUR EMPLOYER TO PAY FOR IT

A difficult question facing many employers and employees is how to identify what AT will best assist an employee with a disability in performing his/her job. Federal regulations suggest that, in order to determine what accommodations are needed, the employer should initiate an “informal, interactive process” with the employee. This process should identify the precise limitations resulting from the disability and potential reasonable accommodations that could overcome those limitations.⁹ Your employer must be made aware that you have a disability that needs to be

accommodated before being obligated to initiate such a process. Because many employers are unaware of what accommodations are possible, it often makes sense to discuss possible accommodations during the job application process. You are not legally required to discuss accommodations, although you may be asked to describe how you would accomplish a task. Many employers have little or no experience in hiring people with disabilities and they may assume that certain disabilities cannot be accommodated or could only be accommodated at great expense. You can help to educate employers by explaining some of the ways you have been, or could be, accommodated on the job.

Employees with disabilities frequently have a good idea of what accommodations they need. Employers are required to consider employee recommendations but may select different accommodations as long as they are reasonable and allow you to perform the essential functions of the job. Often, it will make sense for the employer to hire a consultant with expertise in adaptive technology to assess what types of technology would be most suitable given the type of work, the individual's specific functional limitations and other needed modifications in the work environment. The assessment should also address the need for related services including set-up, training, maintenance and repair.

Most employers will work collaboratively with you to resolve accommodation issues. But if you feel that your employer is not meeting its duty of reasonable accommodation, there are several places to go for help. You can talk to your employer's EEO or ADA officer. If you are receiving vocational rehabilitation (VR) services, your VR counselor may be able to help. You also can get advice and assistance from the Job Accommodation Network (Appendix 1) or, if you are really running into roadblocks, you may find it beneficial to talk to an attorney who specializes in employment and/or disability law.

BRINGING PERSONAL AT TO WORK

Reasonable accommodations also may include permitting an individual with a disability "the opportunity to provide and utilize equipment, aids or services that an employer is not required to provide as a reasonable accommodation."¹⁰ This means that you will generally be allowed to use your own devices, or devices obtained from other sources, at work. This does not mean that your employer can force you to purchase a device if it is appropriately provided as a reasonable accommodation.

OWNERSHIP OF AT PURCHASED BY THE EMPLOYER

If the employer purchases AT, the employer owns it. When the employee leaves, the AT ordinarily remains with the employer. However, in some circumstances, employees have been successful in arranging for the new employer, or the Division of Vocational Rehabilitation (DVR) or Department of Services for the Blind (DSB), to purchase the technology from the former employer.

EMPLOYER RESOURCES

An employer who wants to hire or retain an employee with a disability may be able to obtain financial assistance for the purchase of devices or related services from the DVR, the DSB, or the Department of Labor and Industries (L&I). DVR, DSB and/or L&I will sometimes fund devices and services for their clients in order to facilitate hiring or to assist an employer for whom the cost of such technology would be an undue hardship. The advantage to you, as the consumer, is that the device will be owned by you rather than the employer. The employer also may be able to take advantage of tax credits for expenses incurred to provide access for employees with disabilities.

To summarize, employers covered by the federal and/or state laws described above must provide AT if needed by qualified individuals with disabilities to perform the essential functions of the job or to enjoy equal access to other benefits of employment. Accommodations are not required if it would be an undue hardship for the employer to provide them.

III. B. DIVISION OF VOCATIONAL REHABILITATION (DVR) AND DEPARTMENT OF SERVICES FOR THE BLIND (DSB)

In addition to the nondiscrimination protections in employment and public services and programs, the Rehabilitation Act of 1973 provides funding for vocational rehabilitation (VR) services for persons with disabilities. In Washington state, the two primary agencies responsible for providing these services are the DVR within the Department of Social and Health Services (DSHS) and the DSB. Both of these agencies provide AT for their clients as needed and appropriate to obtain or prepare for employment.¹¹

Individuals are eligible for rehabilitation services from DVR or DSB if they have a mental, physical or learning disability that interferes with their ability to work and they require vocational rehabilitation services to prepare for, secure, retain or regain employment. The presumption is that all people are employable. If a vocational rehabilitation agency determines that an individual is not eligible for services, the burden is on the agency to prove that the individual does not meet the criteria for eligibility. This presumption is included in the law to ensure that people with even the most severe disabilities are provided with the services and opportunities they need to obtain employment.¹²

You apply for vocational rehabilitation services by completing and signing a request for services and a release of information form at a district office of DVR or DSB. District offices are located throughout the state and are listed in telephone directories under the blue pages—State of Washington, Vocational Rehabilitation or Blind Services. DVR and DSB's Web site locations are listed in Appendix 1.

INDIVIDUALIZED PLAN FOR EMPLOYMENT (IPE)

Once a person is deemed eligible for VR services, an assessment of his or her strengths, interests and needs of is conducted—including the need for AT to prepare for and attain employment. Following the assessment, DVR or DSB will hold a planning meeting with the consumer to

develop a written plan of action called an Individualized Plan for Employment (IPE), formerly known as an Individual Written Rehabilitation Plan (IWRP). The consumer has primary responsibility to develop the IPE with assistance from the VR counselor. The IPE establishes the goals, objectives, nature and scope of VR services the person will receive. Any service to be provided or funded by the VR agency must be on the IPE, including AT.

The employment objective of the individual should be consistent with his or her unique strengths, resources, priorities, concerns, abilities and capabilities, and the means to achieve that objective. In determining that objective, it is important to remember that the goal of VR services is not simply to find an individual with a disability a job but rather to empower the individual to *maximize* employability, economic self-sufficiency, independence and integration into the work place and the community.

VR SERVICES AND AT

VR agencies fund a wide range of goods and services related to the individual's employment objective including, among others: medical restoration services; rehabilitation technology; telecommunication, sensory, and other technological aids and devices; "support services" (including personal assistant services and interpreters) and, "assessment, evaluation, and diagnostic services" (including evaluation of "impediments to employment").

AT is funded primarily under the category of rehabilitation technology which is described as the application of technologies, engineering methods and scientific principles to address barriers confronted by individuals with disabilities in education, rehabilitation, employment, transportation, independent living and recreation. Rehabilitation technology also includes AT devices and services. The AT available through VR includes, but is not limited to, the following:

- Assessments to determine eligibility and/or scope of services including an extended evaluation or assessment in rehabilitation technology as needed
- Vocational and training services including personal and vocational adjustment books, materials and tuition to the extent it is not available through other sources
- Training may also include training in the use of artificial limbs, hearing aids and other appliances and devices
- Services to families as needed for the adjustment or rehabilitation of the disabled individual
- Physical and mental restoration services including, but not limited to prosthetic and orthotic devices, eyeglasses, visual services and therapy
- Occupational tools, which are defined as any item that is customarily required for a worker to perform efficiently on the job
- Equipment and initial stocks and supplies
- Transportation in connection with any vocational rehabilitation service

- Telecommunications, sensory and other technological aids and devices, which are defined as electronic or mechanical pieces of equipment or hardware intended to improve or substitute for one or more of a person's senses or for impaired mobility or motor coordination
- Rehabilitation technology services¹³

The type of AT available to a VR participant depends upon the employment goals specified in the IPE and whether AT is needed to reach that goal. If AT is needed to achieve that goal, the IPE should:

- 1) describe the specific rehabilitation technology devices and services to be provided to assist in achieving that goal;
- 2) furnish a statement of how goods and services will be provided in the most integrated setting;
- 3) identify the provider of goods and services; and
- 4) state who will pay for how much of each good or service.¹⁴

Determining what type of AT is needed or appropriate to achieve your employment goals can be difficult. For many people, a critical first step in that process is to obtain a good AT assessment. Your VR counselor should be able to refer you to someone who can perform such an assessment.

For most services, VR considers itself to be the “payor of last resort”—meaning that VR will only pay for the services if there are no other funding sources (called “comparable benefits”) available. Such other funding sources may include Medicaid, private insurance or other resources. *However, VR is not required to look for comparable benefits before it pays for AT.* The fact that AT is not subject to the “comparable benefits rule” shows the important role Congress believes that AT can play in assisting people with disabilities to achieve employment objectives. VR can consider the personal financial circumstances of the participant and can ask him or her to pay for part of the cost of purchasing AT.

AT should be provided without delay once it is part of your IPE. Realistically, the time required for acquisition of the AT and related training will vary. However, consumers do have a right to request an estimate of the time required and to follow up if it appears too much time is being taken.

HINTS FOR GETTING AT FUNDED BY DVR OR DSB

The following “hints” are intended to help consumers effectively advocate for AT within the VR process. You can find more information on the funding of AT through DVR and DSB in the Washington Administrative Code (state regulations that implement federal laws and regulations).¹⁵ Another excellent resource is the Neighborhood Legal Services (NLS) AT Project in New York (Appendix 1).

Justification

To be successful in obtaining AT, it helps to think about several questions. What are DVR and DSB's criteria for funding AT? What does the system allow or not allow? What resources exist to help answer these questions? What information does the consumer have about his or her own limitations and strengths that can best support the need for AT, such as AT assessments or other professional input? Answering these questions will probably take some time. It is important to work with the VR counselor as a team. Counselors are experts in the rehabilitation system, have numerous contacts in rehabilitation engineering and can help with the funding of AT.

It also is important for the consumer to advocate for him or herself. If a counselor tells you that DVR does not fund a certain type of AT as a matter of policy (e.g., DVR does not fund cars or computers), politely challenge that statement. Blanket policies precluding funding of particular types of AT are not permissible under the federal guidelines. The needs of the particular VR client must be considered on a case-by-case basis. If you can establish that a type of AT is truly needed to achieve an employment goal, DVR should provide it. If you need additional advice and guidance, call WATA or the Client Assistance Program which is a federally funded program set up to advocate for VR clients.

Deciding Who Should Pay for AT

For VR clients who need AT, the decision of who pays is not always limited to the client or the agency. Employers in certain situations have the duty under federal and state laws to provide reasonable accommodations to people with disabilities, including clients of VR, whether they are potential employees or current ones. This duty to accommodate may result in the purchase of needed AT by the employer. However, in some cases, VR may fund the AT needed by a client. If VR funds AT, it does not "release" an employer's responsibility under the ADA or other disability rights laws. A VR counselor may choose to fund such devices and services to facilitate employment or to assist an employer for whom payment for such accommodations would be an undue hardship.

The question of whether a college or VR should pay for AT and related services for VR clients attending school can be difficult. Colleges are required to make reasonable modifications to their programs and services in order to accommodate the needs of students with disabilities. Such modifications should include adaptive hardware and software in computer labs and libraries as well as access to the Internet and other forms of electronic technology. However, colleges are not required to provide "personal" devices and services for students with disabilities (e.g., wheelchairs or laptops). If your employment goal requires attending college, you should work with your counselor to determine the AT that VR will provide. For example, to get VR to pay for a personal computer or laptop, you likely will need to show that the school's facilities do not meet your particular needs—either because of limitations in the facility such as, hours available, type of equipment, etc., or because of other personal factors such as, fatigue relating to your disability, your work schedule or other relevant factors.

Focus on Function, Not Gadgets

The purpose of AT is to assist a person in performing certain tasks and improving functional capabilities. Consumers are often “wowed” by new and fancy gadgets. These gadgets may not be the most effective or cost efficient way of doing things. A good assessment, performed by an AT specialist, can go a long way in assuring that the correct device is chosen. The AT assessment can be paid for by DVR or DSB, and is often included as part of the IPE.

Think Long Term

The ultimate goal of vocational rehabilitation is independence. Think twice about devices that will require frequent replacement or on-going support if equally effective options are available that will not require such support. After your case is closed, you may have to assume the cost of ongoing maintenance and support for the device. Can you afford to do so? An additional issue in thinking in the long term is the relative stability of your particular disability. If you are undergoing functional changes and your AT needs are likely to change over time, talk to your counselor about how this issue and how these changing needs can be accommodated. Can some of your AT be rented rather than purchased? Can you work out a plan that will accommodate these needs over time?

AT Ownership

AT purchased by DVR or DSB remains the property of Washington state until one of the agencies decides to sign it over (transfer ownership) to the consumer. Typically ownership transfer occurs after you have obtained stable employment. Defining “stable employment” is a very tricky and subjective process that is always decided on a case-by-case basis. Stable employment can be generally defined as the point when it can reasonably be assumed that no more assistance will be needed for the client to remain successfully employed. Effective communication between the consumer, the VR staff and the employer will be key in determining whether stable employment has been reached.

Specifics of AT Acquisition Through DVR and DSB

Although DVR and DSB have similar goals and many similar policies regarding AT in providing vocational assistance to their clients, there are some unique aspects to each agency, which are noted below.

ACQUIRING AT THROUGH THE DVR SYSTEM

Computer Purchases

To obtain a computer through VR, you must show that you need a computer to achieve the employment goals specified in your IPE. Once again, an AT assessment by a qualified AT professional—paid for by VR—will be a critical part of the process. Each DVR region has staff known as Computer Information Consultants. These individuals will be consulted on computer-

related purchases. A regional committee reviews all computer purchases and this review is usually the final step in approval, although in extremely complex or expensive cases the decision may be passed on to the state level. If the computer involves any additional AT—switches, voice activation, etc.—the counselor will also consult with the Regional Medical Program Consultants (RMPC).

Transportation Costs and Vehicle Purchases

DVR will pay for transportation that is necessary to look for work. The means of transportation likely to be provided include a bus pass or possibly taxi script. Vehicles of any kind will be more difficult to get funded by the agency. The primary concern will be that the purchase relates to and strongly supports the employment goal. Considerations include:

- Is this means of transportation the cheapest alternative while maintaining necessary effectiveness? For example, can the consumer ride the bus? If no, why not?
- Does the client use a wheelchair that doesn't fit effectively on a bus?
- Does the client live in an area not serviced by bus routes?
- If a vehicle is needed, what kind? What are the plusses and minuses of each model?

As a general rule, you will need to be able to prove why cheaper alternatives do not meet critical employment requirements. A VR-funded assessment performed by an AT professional can help in preparing the justification you will need.

If DVR purchases a vehicle as part of your IPE, generally you must pay for, and have a plan to continue paying for, insurance that completely covers the vehicle. You must also have a plan to continue paying for repair and upkeep costs of the vehicle. There are some exceptions to this policy, which would have to be negotiated with your counselor.

Purchase of a van or car requires an exception to policy—it is not standard DVR process. As a result, you can expect the process to involve approval from several levels of DVR staff and often, long delays. Multiple estimates for services and goods will be needed. Although DVR staff can provide these estimates, your involvement and cooperation can expedite the process.

Motorized Chairs

Many of the requirements for purchasing motorized chairs are similar to the requirements for obtaining transportation. You will need to prove why this type of chair is the least expensive option while remaining effective. Is a wheelchair necessary for movement around the office? Does the disability make pushing or operating a wheelchair significantly difficult and interfere with work activities? Will it be necessary to carry or operate items, while pushing the chair? Is pushing a wheelchair likely to be overly fatiguing, etc.? An assessment by a qualified AT specialist will be necessary and paid for by DVR. Consultation with the RMPC will also be used. The consultant will assist the counselor in determining whether certain options meet your needs as well as follow DVR policy.

Telecommunication, Sensory and Other Technological Aids and Devices

All of the following criteria must be met in order to receive telecommunication, sensory and other technological aids and devices from DVR:

- 1) the individual's disability warrants such devices or aids;
- 2) there is no less expensive or more efficient method of accommodating the individual's disability;
- 3) the aid or device is necessary to the client's vocational rehabilitation program;
- 4) no medical contraindication exists;
- 5) the client's disability is stable enough that the client will benefit from the aid or device over a prolonged period of time; and
- 6) the device or aid meets established engineering and safety standards.

Purchase of Occupational Tools and Equipment and Other Goods and Services

Occupational tools and equipment may be provided when necessary for the client to achieve suitable employment. Tools may be provided during training programs or to enable the client to become employed. Tools are limited to those that trainees and employees are normally required to provide or special tools that are necessary because of the client's disability. Equipment may be provided if it is required for participation in an occupation or is necessary because of the client's disability.

Other goods and services, including certain AT, may be provided when necessary to the successful outcome of a client's vocational rehabilitation. These may include modifications and repairs to real property, limited to barrier removal and construction of partitions and other portable modular components. In addition, services may be provided to a client's family if the service is necessary to support the client's vocational adjustment or vocational rehabilitation. This may include training to use AT provided by DVR.

ACQUIRING AT THROUGH THE DSB SYSTEM

DSB has a separate unit dedicated to the evaluation, selection and use of AT by clients. DSB counselors can use this unit at any time during their work with the client. Counselors will refer clients to the AT unit for a specific period of time, usually for the amount of time expected to resolve AT issues. During this time the AT specialists will have access to your case.

The AT unit has an AT equipment lab where evaluations are conducted. This evaluation will involve direct interaction with the client, hands-on experience with various technology options, real-life situation assessment, assessment of client attitude and abilities, review of previous training and evaluation of the impact of other disabilities.

AT unit staff are available to conduct training at the work site, including training in the use of commercial software applications and in the use of many unique specific devices. The AT unit

may on occasion choose to refer this training out to another vendor. Additional training and follow up is available once a client has started working, particularly in the first 60 days. This may include phone calls, on-site visits or additional training.

The following requirements apply to the purchase of AT while in a training program:

- No AT will be authorized without an appropriate referral from the AT unit.
- The training program must be in accordance with the IPE goal.
- A job-site analysis is required for an internship. A training-site analysis is required if modifications are being considered for campus.
- AT may be purchased if the training program, as part of the curriculum in the agreed upon area, requires access to specific computer software and/or hardware.
- The participant must use or access materials such as charts, graphs, or technical information to complete the course or curriculum.
- The provision of AT will significantly reduce the need for usage of a reader.
- The client will function more independently and competitively in training using specific AT devices for note taking.
- The client is enrolled in an accredited work-experience program—i.e., on the job training (OJT), internship, etc.—and requires specific AT devices to accommodate identified job functions.

Because the DSB statewide Higher Education Project has assisted many colleges and universities in purchasing AT devices for use by blind students, this equipment pool must be examined before acquisition of additional AT can be authorized for new clients enrolled in higher education.

In order for DSB to purchase AT in employment, it must be clearly stated to employers that DSB's purchase does not in any way remove the employer's responsibility to provide AT where appropriate. In general, DSB is more likely to purchase AT when the client is a new hire or has been reassigned, as reasonable accommodation, to a position with significantly different duties. DSB is also more likely to purchase AT if the employer proves that providing a reasonable accommodation would in fact cause an undue hardship, according to the ADA, or the employer is not covered by state or federal law. An AT assessment must occur before any AT is purchased.

In summary, vocational rehabilitation services help people with disabilities prepare for, obtain, or retain employment. Many clients of VR—either DVR or DSB—will have an IPE that includes educational goals, job-skill training, or assistance with job accommodations and modifications. AT is often included in the IPE to assist in successfully gaining independence in a work environment. For more information about funding AT through vocational rehabilitation programs, you may wish to review the publication, *State Vocational Rehabilitation Agencies and Their Obligation to Maximize Employment*, which can be found at the Neighborhood Legal Services Web site (Appendix 1).

III. C. SOCIAL SECURITY ADMINISTRATION (SSA) PROGRAMS

The federal Social Security Administration (SSA) is responsible for administering the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. SSI and SSDI include some important work-incentive programs that can be used to fund AT for use in employment or preparation for employment.

SUPPLEMENTAL SECURITY INCOME (SSI)

SSI is an income-support program that provides monthly payments to persons who have disabilities and limited income and resources. Eligibility for SSI benefits is based on your financial need and does not require that you have worked or paid Social Security taxes in the past. In this way it is different from other benefits under the SSA—such as Social Security retirement benefits or SSDI, which is described below. The specific criteria for SSI eligibility are complicated and will not be reviewed in this manual. In general, you must have income or “substantial gainful activity” under \$700 per month; have resources under \$2,000, excluding your home and automobile, and be 65 years of age or older or have a disability. Children as well as adults can qualify for SSI on the basis of disability. The federal government funds a basic rate for SSI and each state government supplements that rate. People who qualify for SSI are automatically eligible for Medicaid which can be a very important resource for providing access to AT.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

SSDI is designed to provide income support for people who are unable to work due to injury or disability. The benefits consist of both disability payments and Medicare (available after you have been on SSDI for two years). Unlike SSI, your eligibility for SSDI does not depend on your income or your savings and other financial resources. To be eligible for SSDI, two conditions must be met. First, you must have a physical or mental impairment that is expected to prevent you from engaging in substantial gainful activity (SGA) for a year or more or have a condition that is expected to result in death. Generally, an earned income over \$700 a month will preclude you from meeting this condition for eligibility. Second, your eligibility depends on your contributions to the Social Security system during your employment. To be eligible, you must have worked 20 quarters of the 40-quarter period ending with the quarter in which you are determined to be disabled or, in other words, 20 quarters out of the last ten years.

If you return to work after you are on SSDI, your disability payments can continue during a nine-month trial work period. The rules regarding trial work are complicated. However, the advantage for AT users is that you can use the extra money you are receiving from SSDI during the trial work period—the amount in addition to your employment income—to purchase needed AT. Another real benefit to SSDI is that your Medicare coverage can continue for a certain period of time even after the end of the trial work period. By continuing Medicare eligibility, you can protect this important source of AT funding for the future. There are other rules that determine eligibility so it is important to clarify your eligibility with the appropriate SSA office.

SSA WORK-INCENTIVE PROGRAMS

SSA has three work-incentive programs that can fund AT used for work or preparation for work. Whether these work incentives are appropriate for you will depend on many factors. As with all funding sources, there is a multitude of rules and procedures that must be followed to take advantage of the work-incentive programs. Check with your local SSA office if you think that these programs might be a useful avenue for funding your AT needs.

PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

A PASS is a plan that allows you to set aside income and resources, which would otherwise be considered in calculating a reduction in the amount of your benefit check from Social Security, to purchase goods or services intended to help you become self-supporting. A PASS can be used to reach an education-related goal, receive vocational training or start a business. You also can use a PASS to purchase needed AT. Examples of acceptable purchases under a PASS include computers, modified vehicles, educational and training costs, equipment, tools, medical and social services costs, attendant and child care and job coaching expenses. The funds in a PASS, however, can only be used for purposes approved by Social Security and listed in the PASS. A PASS must be in writing and approved by SSA. A PASS is periodically reviewed. Anyone can help you write a PASS, but it is best to get some assistance from a Social Security case worker, VR counselor or other individual skilled in writing them. Before writing your PASS, be sure to review other potential sources of funding that may be able to purchase these items for you—such as Medicaid, DVR or your employer. Information about writing a PASS is available on the NLS Web site (Appendix 1).

IMPAIRMENT-RELATED WORK EXPENSES (IRWE)

Impairment-related devices or services are work expenses (IRWE) that can be deducted from your total pre-tax earnings as long as you actually pay for the device or service and are not reimbursed from another source. IRWEs can benefit you enormously in the calculation of your earnings and continued eligibility for SSI and SSDI benefits. An IRWE is the cost of an item or service that is related to your impairment and enables you to work. IRWEs also can be deducted by employees or those who are self-employed from their taxes. The amount you deduct must be reasonable and is considered reasonable if it is comparable to charges for the same item or service in your community. Examples of deductible expenses include:

- AT devices such as wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment, and orthopedic braces
- AT related to work such as one-handed typewriters, page-turning devices, Braille devices, and telecommunication devices
- Transportation costs related to work such as drivers or cabs (if such special transportation is not generally needed by individuals without impairments), mileage expense for an approved vehicle, and wheelchair lifts
- Modifications made to a vehicle needed for work
- Services such as readers, interpreters, and job coaches

- Expenses related to a guide dog
- Medical costs such as routine drugs, prescribed medical treatment or therapy that is necessary to control a disabling condition and the physician's fee related to these services
- Diagnostic procedures (including AT) if the objective is related to the control, treatment, or evaluation of a disabling condition
- Other AT devices when such devices are essential for the control of a disabling condition (either at home or at work) such as an electric air cleaner for an individual with severe respiratory disease

As this list illustrates, the types of AT and related services that can be funded as IRWEs are extremely varied. However, remember that you must actually pay for the IRWE and it must enable you to work. If the AT you want to deduct is primarily for cosmetic purposes or home modifications (if you don't work at home) it will not be allowed as an IRWE deduction. It is important to document everything in writing for the IRS, including a physician's recommendation in the case of medical AT.

BLIND WORK EXPENSES

Persons who are legally blind can use the related category of Blind Work Expenses (BWE) in calculating income for the purposes of determining SSI and SSDI eligibility. Some of these deductions are special deductions that are not available to persons with other disabilities. These deductions include: federal, state and local income taxes; Social Security taxes; mandatory pension contributions, and meals consumed during work hours. Examples of AT that might be deductible as BWE include any AT and related training that is reasonably related to working—for example, training on computer access, mobility training, Braille, purchase of a guide dog and related expenses.

III. D. WORKERS' COMPENSATION INSURANCE—DEPARTMENT OF LABOR & INDUSTRIES (L&I)

Washington state employers are required to provide workers' compensation insurance for their employees. If you are injured at work or in the performance of your job, you may be eligible for benefits that can include AT. In Washington state, the workers' compensation program is managed by the Department of Labor & Industries (L&I). Employers have the option to either self-insure or to purchase insurance from L&I. L&I is both insurer and administrator and monitors its actions and decisions and those of self-insured employers. The benefits available to workers should be the same regardless of whether their employer is self-insured.

L&I provides seven different types of benefits for injured workers:

- 1) Medical benefits
- 2) Temporary total disability
- 3) Temporary partial disability
- 4) Permanent total disability

- 5) Permanent partial disability
- 6) Vocational benefits
- 7) Death-related benefits

The medical benefits cover medical expenses for industrial injuries or occupational diseases, typically including the cost of doctors, hospital, surgical and other medical services necessary for the treatment of the workplace injury or disease. Other medical services include occupational therapy, physical therapy, medical equipment, prosthetic devices, attendant care, and medical rehabilitation. The goal is to achieve the “maximum medical improvement” for the worker—i.e., the best health status after treatment that can reasonably be expected.

Washington’s workers compensation law also lists specific benefits and rights to AT. It states that:

- Every worker whose injury results in the loss of one or more limbs or eyes shall be provided with proper artificial substitutes.
- Every worker whose hearing aid or eyeglasses or lenses are damaged, destroyed, or lost as a result of an industrial accident shall have the same restored or replaced.
- All mechanical appliances necessary in the treatment of an injured worker, such as braces, belts, casts, and crutches, shall be provided and all mechanical appliances required as permanent equipment after treatment has been completed shall continue to be provided or replaced without regard to the date of injury or date treatment was completed, notwithstanding any other provision of law.¹⁶

The law also provides for residential home modifications (not to exceed an amount equal to the state’s average annual wage) and modifications (not to exceed 50 % equivalent of the state’s average annual wage) to motor vehicles owned by a worker who has become an amputee or paralyzed because of an industrial injury.¹⁷

AT also may be available as a “vocational benefit” provided at the discretion of L&I. If vocational rehabilitation is considered appropriate, a return-to-work plan is developed by a private provider and approved by L&I. The plan provides a written rationale for the individualized plan, strategies for achieving the goal selected, an estimate of the time and costs involved, documentation to support the feasibility of the goal and responsibilities of the parties.

The law establishes cost maximums for certain services provided as part of the return-to-work plan. Regarding AT, if job modification is necessary to enable the worker to return to work, L&I may pay up to an additional \$5,000 per worker per job modification in cooperative effort with the employer.¹⁸ Vocational rehabilitation benefits can include the cost of books, tuition, fees, supplies, equipment, transportation, child or dependent care, and other necessary expenses for the worker but can not exceed \$3,000 in any 52 week period.¹⁹ This benefit can include the cost of tools and other equipment necessary for self-employment or re-employment. The tools and equipment will become the property of the worker at the end of the return-to-work plan if the goal has been met. If unsuccessful, the tools and equipment return to L&I.

The return-to-work plan may cover other expenses including case management, job placement, job retraining and adaptive equipment needed for employment purposes. Depending on the needs of the individual worker, AT that can be covered includes home and van modifications, AT assessments related to job functions and physical capacity evaluations.

Please contact the Department of L&I for information regarding the other benefits of workers' compensation (Appendix 1).

OTHER WORKERS' COMPENSATION PROGRAMS

Besides the state workers' compensation program, there are a number of federal programs that provide for compensation to injured workers. If you are eligible for these programs, check with your employer or union for specific information on AT coverage. Legislation mandating other workers' compensation programs includes:

- Federal Employees Compensation Act (FECA), which provides coverage for federal employees and their dependents for death or disability resulting from personal injury sustained in the performance of their job duties.²⁰ Similar benefits are provided to members of the Armed Forces for injuries sustained “in the line of duty.
- Federal Employers Liability Act (FELA) applies to employees of common carriers; unlike most workers compensation programs, employees are required to establish employer negligence in order to qualify for benefits.²¹
- Jones Act provides workers compensation remedies to seamen; together with common law remedies, the Jones Act provides for “maintenance and cure,” and, in some cases, punitive damages against maritime employers.²²
- Longshore & Harbor Workers Compensation Act provides workers' compensation benefits for longshoremen and other maritime workers employed on navigable waters.²³
- Black Lung Benefits Act provides income maintenance for coal miners and their dependents for injuries/death related to pneumoconiosis—black lung disease.

CHAPTER III NOTES

¹ 42 United States Code (U.S.C.) §§ 12101-12213.

² 29 U.S.C. § 791, 793, 794.

³ Revised Code of Washington (RCW) 49.60.

⁴ Job Accommodation Network, *Evaluation Report Executive Summary* (April 1987).

⁵ 42 U.S.C. § 12112(9)(B); 29 C.F.R. § 1630.2(o)(2)(ii).

⁶ 29 Code of Federal Regulations (C.F.R.) § 32.4(e).

⁷ 29 C.F.R. § 33.11(a)(2).

⁸ It should be noted, however, that employers normally are not required to provide employees with personal devices and services—e.g., hearing aids, wheelchairs or augmentative communication devices.

⁹ 29 C.F.R. § 1630.2(o)(3).

¹⁰ *ADA Title I EEOC Interpretation Guidance* 29 C.F.R. § 1630.2(o).

¹¹ Native Americans living on some reservations in Washington are served by separate rehabilitation programs known as Section 130 programs. 29 U.S.C. § 750(e). Native Americans who qualify for Section 130 programs may seek services from their reservation-based program or from DVR or DSB.

¹² 29 U.S.C §§ 701 *et seq.*; 34 C.F.R Part 361.

¹³ 29 U.S.C. § 723(a)(1)-(16). The Rehabilitation Act defines “rehabilitation technology” as “the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas which include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.”

¹⁴ 29 U.S.C. § 722(b)(1)(B).

¹⁵ The rules for DVR start at Washington Administrative Code (WAC) 490-500-005. AT is discussed in WAC 490-500-418. These rules are currently being revised. The proposed rules can be found on the Web at <http://www.wa.gov/dshs/dvr/aboutdvr/rehabact.htm>. The rules for DSB start at WAC 67-25-005. AT is discussed at 67-25-432. More specifics also can be found in DVR and DSB policy manuals and statements. The manuals are not readily available but can be requested from the agencies themselves.

¹⁶ RCW 51.36.020.

¹⁷ RCW 51.36.020(7)(8).

¹⁸ RCW 51.32.250.

¹⁹ RCW 51.32.095(3).

²⁰ 5 U.S.C. § 8101 *et seq.*

²¹ 45 U.S.C. § 51 *et seq.*

²² 46 U.S.C. § 688 *et. seq.*

²³ 33 U.S.C. § 901 *et seq.*

CHAPTER IV

EDUCATION-RELATED SOURCES OF ASSISTIVE TECHNOLOGY FUNDING

Chapter IV describes the rights of students with disabilities to AT in education, including public and private elementary and secondary schools and higher education. This chapter also discusses other options for funding AT for students with disabilities. If you have additional questions about the funding of AT in educational settings, please refer to the resources mentioned throughout this chapter or contact WATA staff.

IV. A. PRIMARY AND SECONDARY PUBLIC SCHOOLS

Children who qualify for special education services under the Individuals with Disabilities Education Act (IDEA) are entitled to receive AT as needed to ensure that they are receiving a “free and appropriate public education” (FAPE). Children with disabilities also have rights to AT that are defined by Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act (ADA) and the Washington State Law Against Discrimination. These nondiscrimination laws require schools to accommodate the needs of children with disabilities (including those who do not qualify for IDEA) in order to provide, to the extent possible, an equal opportunity to enjoy the educational benefits offered by their district.

Although both IDEA and the nondiscrimination laws require schools to provide AT for children with disabilities, there is an important difference between them. Under IDEA, the state provides schools with extra funding for each child designated as receiving special education services. A small percentage of this funding comes from the federal government; the rest comes from the state general fund. Under the nondiscrimination laws, schools do not receive any special funding or reimbursement for expenses incurred in accommodating children with disabilities. Funding for such accommodations comes from the school’s “general” fund. Although this funding difference does not impact a child’s legal rights in any way, it may be easier for a child to obtain AT if he or she is requesting it under IDEA rather than the civil rights statutes.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a federal law that requires states to ensure that children with disabilities between the ages of 3 and 21 receive FAPE, which emphasizes special education and related services designed to meet their unique needs. Congress has appropriated funds to the states to achieve the goal spelled out in the federal law.

In this manual, we address only the IDEA sections relevant to obtaining AT for special education students. Those include:

- a) the obligation to provide special education and related services as needed to ensure FAPE;
- b) the obligation to provide education in the least restrictive environment (LRE) based on the student's needs, to the maximum extent possible;

- c) the requirement that school districts prepare a written individualized education program (IEP) for each student with disabilities (to be jointly developed by parents and staff), which specifically considers AT needs;
- d) the right to an independent educational evaluation; and
- e) the provision of AT for students in transition.

Many resources are available on the rights of students with disabilities. For specific information on rights to special education, you will find helpful publications on the Web site of the Office of the Superintendent of Public Instruction (OSPI)—including the Washington regulations that implement IDEA¹ and the Legal Guide to Special Education Services (Appendix 1). Copies of the IDEA Amendments of 1997 and implementing regulations as well as commentary and explanation are available on the U.S. Department of Education's Web site (Appendix 1). A helpful publication for parents and advocates is *The Public School's Special Education System as a Funding Source: The Cutting Edge*. The publication is a joint project of the United Cerebral Palsy Association's Assistive Technology Funding and Systems Change project and Neighborhood Legal Services (NLS). It is available at the NLS Web site (Appendix 1).

a) Special Education and Related Services

IDEA and Washington law require that children with disabilities be provided a FAPE consisting of special education and related services.² Special education is instruction that is specifically designed to meet the needs of the child and is provided at no cost to the parent. Special education can include instruction carried out as part of speech and language services, physical and occupational therapy, orientation and mobility instruction, behavioral intervention and audiological services. AT may be applicable in any of these areas.

Under IDEA, districts must also ensure that students receive related services if needed to achieve FAPE. Although IDEA includes a list of services that are considered related services, the list is not exhaustive. Any service that is needed for a child to benefit from special education—with the exception of medical services, unless for diagnostic or evaluative purposes—must be provided. AT is clearly included in related services.³

Although districts have been obligated to provide AT if necessary to ensure FAPE since the special education law was passed in the mid 1970s, Congress first formally acknowledged the role of AT in special education in 1990 when it amended IDEA to include definitions of AT devices and services taken directly from the Tech Act.⁴ These definitions encompass a wide variety of adaptive technology including, computer hardware and software, augmentative communication devices, typewriters, tape recorders, Braille printed materials, auditory trainers, and personal devices such as wheelchairs, hearing aids and eyeglasses where needed for a child to achieve FAPE. Washington state's definition of AT is virtually identical to the IDEA definition.⁵

b) Least Restrictive Environment (LRE)

One of the most significant decisions faced by parents and educators alike is where a child with special needs should be educated. Both IDEA and Washington state law require that students with disabilities be educated in the *least restrictive environment* (LRE). This mandate includes non-academic and extracurricular services and activities. The presumption is that all students will be educated in the regular education environment with the help of supplementary aids and services, unless the unique needs of a student require a more restrictive placement to ensure FAPE.

In Washington, supplementary aids and services are defined to include AT.⁶ AT may allow a student to benefit from education in a LRE. Thus, the potential benefits of AT must be considered in determining the appropriate placement.

c) Individualized Education Program (IEP)

Every child who receives special education services must have an Individualized Education Program or IEP. This crucial document is intended to guide the child's educational development. The IEP is created by the student's IEP team with substantial input from the child's parents.

The 1997 amendments to IDEA added a "special factors" section. The use of AT devices and services is one of the special factors to be considered by an IEP team in developing a student's IEP.⁷ In effect, this means that the potential educational benefits of AT should be considered, and documented, by every child's IEP team.⁸

The IDEA regulations provide little guidance on what it means for an IEP team to "consider" a student's AT needs. However, the regulations do require that, at the discretion of the parent or school, the IEP team includes "other individuals who have knowledge or special experience regarding the child."⁹ Thus, at a minimum, parents thus should expect that the student's AT needs will be assessed or evaluated by someone with expertise in the particular AT relevant to the child's disability.

Some districts have individuals on staff with specialized training in AT; others do not. If the district does not have a staff member with the needed expertise, it can contract for an expert consultation with another district, the OSPI Educational Technology Center or an outside consultant. Based on this assessment, the IEP team should determine what AT is needed to meet the unique needs of the individual student. This determination should be incorporated into the student's IEP.

Many parents report that their biggest struggle has been to obtain adequate support for use of a device—particularly in the general education classroom—once it has been purchased.¹⁰ Issues such as integration into the student's school day, staff training, warranties, insurance and repairs should be addressed during development of the IEP. It is essential to specifically identify what support services (particularly training) will be provided. Repair and maintenance issues to address

include whether a loaner or alternative system will be provided to ensure that the IEP can be implemented when a device is out of commission.

d) Independent Educational Evaluation (IEE)

One of the rights provided to children with disabilities under IDEA is the right to an independent educational evaluation (IEE). If a parent is not satisfied with the district's evaluation or assessment, he or she can request an IEE by an outside evaluator. Parents can ask that the school pay for this IEE and generally the school will be obligated to do so.¹¹ The right to an IEE extends to situations where the school has failed to conduct any AT evaluation or failed to conduct a proper evaluation. Alternatively, a parent can ask the school to re-evaluate the student's AT needs.¹² However, such a request is appropriate only if the school district has access to personnel with expertise in the types of AT that might be needed by that student.

The school district must provide information about where to obtain an independent evaluation, when requested by a parent. You can also obtain such information by contacting WATA. Once the district receives notice of the parent's intent to obtain an IEE, it has 15 days to file a request for a due process hearing challenging the request.¹³ Otherwise, the district may become obligated to pay for it.

e) Transition Services and AT

The "transition services" requirement was added to IDEA in 1990. Under this provision, a statement of needed transition services must be included in all IEPs for students beginning at age 16 and younger, if appropriate.¹⁴ The 1997 amendments to IDEA require districts to include a statement of transition needs in the student's IEP, beginning at age 14. This statement should identify any needed coursework relevant to achieving the child's post-secondary goals (such as participation in advanced placement courses or a vocational education program).¹⁵

Transition planning should address all aspects of "post-secondary" life for students with disabilities including post-secondary education, employment, transportation and independent living. The student's post-secondary AT needs should be considered as an integral part of the transition planning process.

REHABILITATION ACT OF 1973 (SECTION 504), THE AMERICANS WITH DISABILITIES ACT (ADA) AND WASHINGTON STATE LAW AGAINST DISCRIMINATION (RCW 49.60)

Schools also have an obligation to provide AT to students with disabilities under federal and state nondiscrimination laws. The relevant federal laws include Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act. Both of these laws prohibit public entities and recipients of federal funds from discriminating against persons with disabilities. Although there are some differences between the ADA and Section 504, they are not significant—at least when it comes to funding AT for students with disabilities—and we will discuss Section 504 only. The Washington State Law Against Discrimination (RCW 49.60) is also a non-discrimination statute. Basically all three laws require schools to make buildings and programs, both academic and non-

academic, equally accessible to students with disabilities. The laws apply to all students with disabilities—including those who need special education services and those who do not.

Like IDEA, the Section 504 regulations require that districts provide FAPE to students with disabilities. Appropriate education means the “provision of regular or special education and related aids and services that . . . are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met . . .”¹⁶ Related aids and services clearly include AT.

Also like IDEA, Section 504 requires that students with disabilities be educated to the maximum extent appropriate in the regular education environment. When making educational placement decisions, information must be gathered from a variety of sources, including evaluations and input from parents, teachers and other professionals who are knowledgeable about the child, evaluation data and placement options. To comply with the LRE requirement, schools may be required to provide the student with supplemental aids and services including AT.

The school district's duty to not discriminate under Section 504 also extends to nonacademic services. Nonacademic and extracurricular services include counseling, physical education and recreational athletics, transportation, health services, special interest groups or clubs, career counseling and employment. AT also can play an important role in meeting the school district's obligations with respect to providing maximum access to such activities and services.

Public entities (including schools) are not required, under Section 504 or the ADA, to provide personal devices or services such as: wheelchairs; prescription eyeglasses or hearing aids; readers for personal use or study, or services of a personal nature including assistance in eating, toileting, or dressing.¹⁷ No such limitation is mentioned in IDEA and the U.S. Department of Education has indicated that there are circumstances in which a school district must provide personal devices (e.g., hearing aids and eyeglasses) to students eligible for special education services under IDEA.

Although RCW 49.60 does not specifically mention AT, schools may be required to provide such technology as part of their duty to make “reasonable accommodation to the known physical, sensory or mental limitations of a handicapped person when same services would prevent the person from fully enjoying the place of public accommodation.”¹⁸ Whether an accommodation is reasonable depends upon its cost, the size of the place of public accommodation, the availability of staff to make accommodation, the importance of the service to the person with a disability and other factors, as discussed in Chapter III.

In most cases, RCW 49.60 will not add additional rights or responsibilities relevant to the AT needs of children with disabilities since it adds little to the requirements imposed by the IDEA, the ADA and Section 504. In addition, like ADA and Section 504, there are no additional funds available for services under RCW 49.60. However, this law could be important in defining the obligations of private, nonsectarian schools to provide AT.

COORDINATING SERVICE DELIVERY

Under IDEA parents cannot be asked to pay for special education services, including AT, if these services are required as part of the child's FAPE. However, schools are free to seek out and use funding from other sources including Medicaid and DVR as long as this process does not delay the provision of AT needed by the child to achieve FAPE. In Washington, school districts are *required by state law* to pursue reimbursement from Medicaid for Medicaid-covered services provided by the school district.¹⁹ This requirement allows the state to capture the federal dollars provided through the Medicaid match for these services. A small portion of the amount requested for reimbursement is returned to the district (a maximum of about \$20 out of every \$100).

Services eligible for reimbursement under Medicaid include those that are diagnostic, evaluative or rehabilitative in nature. These services must be medically necessary as identified in the child's IEP or referral for evaluation. These services include:

- Occupational therapy
- Physical therapy
- Speech therapy
- Audiology evaluation
- Nursing services
- Psychological services

Although AT is not specifically mentioned, any of these services fall under the definition of AT. Parental consent is required under the Family Education Rights and Privacy Act (FERPA) before a district can request Medicaid reimbursement.

Pursuit of reimbursement from a child's private health insurer also requires consent of the child's parents. Districts are required to send parents a letter explaining that such pursuit is voluntary together with a consent form authorizing the school to pursue reimbursement from the carrier. These guidelines were developed in response to case law finding that school districts may not force parents to pursue their own private insurance to fund special education services if doing so would deprive them of their policy benefits, for example, by depleting dollars available under annual or lifetime caps.

The 1997 amendments to IDEA also require the state educational agencies (in Washington, OSPI) to develop interagency agreements with Medicaid, DVR and other relevant agencies. These agreements must outline the responsibilities of each agency and provide a mechanism for schools to be reimbursed when they pay for services that should be funded by another agency.

HOME SCHOOLING AND AT

If your child is being home schooled, you can receive special education services—and possibly AT—from your district by enrolling him or her as a part-time student. You must complete the appropriate paperwork to enroll. Check with the district to see if they have a special form for part-time enrollment. In completing this form, be clear on your expectations for services and

equipment you want the district to provide. The next step is to get the appropriate items into the IEP in such a way that the AT can come home with the child. Ordinarily, schools are under no obligation to provide services at home unless the child qualifies for home- or hospital-based instruction. AT will only be approved to go home with the child if necessary for the child to receive FAPE. You will need to establish (a) that your child needs AT at home to achieve FAPE and (b) that having the AT at home is consistent with the services requested in your part-time enrollment request. To establish the need for a device, you should request an AT assessment for your child. Such an assessment by a qualified professional will address the need for AT devices and related services, including training. The IEP should also address the types of ongoing services needed to support the use of the device and the circumstances under which the device will be sent home. More information about home-based instruction can be obtained from the OSPI Web site (Appendix 1).

THINGS TO REMEMBER ABOUT AT FUNDING FOR SCHOOL

- ◆ Students sometimes pay for and bring family-owned AT to school. If the device breaks or needs repair, the district can be asked to pay for these repairs if the AT is mentioned in the child's IEP or is otherwise essential to the student's education. Having the district pay for the repairs makes sense since the agency would otherwise be required to purchase and maintain the needed device.²⁰
- ◆ Under IDEA (but not necessarily ADA or Section 504), when a district has determined that a child with a disability requires a hearing aid in order to receive FAPE and the child's IEP specifies that the child needs a hearing aid, the district is responsible for providing the hearing aid at no cost to the child and his or her parents.²¹
- ◆ A school district cannot require parents to seek outside funding for AT through Medicaid, private insurance or other sources. It is the school district's responsibility to provide AT where needed. School districts also may not force parents to use their private insurance when the parents would face a realistic threat of financial loss such as: (a) an increase in premiums or discontinuation of a policy; (b) an out of pocket expense, such as a deductible (districts should pay these), or (c) a decrease in available annual or lifetime coverage. However, schools are free to seek out and use funding from other sources including Medicaid and vocational rehabilitation as long as the process does not delay the provision of needed services.²²
- ◆ The student's initial eligibility assessment should include an AT assessment because a child must be assessed in all areas related to a suspected disability.²³ AT assessments focus on the extent to which the student would benefit from the use of assistive devices in terms of maintaining, increasing or improving functional capabilities. Both state and federal regulations require school districts to ensure that AT is provided to the student, if needed, as part of a child's special-education-related services or supplementary aids and services. As defined by IDEA, AT services clearly include AT assessments.

- ◆ Whether funded under Section 504, ADA or IDEA, if the school district pays for an AT device, it remains the property of the district. If the device is purchased by the family, through private insurance or through Medicaid or DVR, then ownership rests with the child and his or her parents.
- ◆ Students should be permitted to take AT home when they need it to do homework or otherwise achieve FAPE. Before taking a device home, the child's family should confirm that the school district's insurance will cover any loss or damage to the device. To the extent that the district charges families for damage to other school-owned equipment which is sent home (e.g., musical instruments), the district may have the right to charge for damage to school-owned AT, unless it stems from normal wear and tear. On the other hand, the school remains obligated to maintain the device in good repair and cannot condition a child's ability to take the device home on the family's ability to pay for repairs. Some districts ask parents to sign a statement indicating that they will be responsible for the device if it is lost, stolen or broken due to mishandling. This may not be enforceable under IDEA; it is clear that districts cannot hold parents responsible for the normal wear and tear of AT. In any event, you should find out how to care for the AT. You also should be sure that there is adequate insurance coverage through the district or your homeowner's or renter's policy to cover replacement.
- ◆ If necessary for the child to receive FAPE, the school district is responsible for ensuring that training for the child, parent, teacher or occupational therapist on use of the AT is provided. The definition of AT services included in both federal and state law includes training for an individual with disabilities or, if appropriate, for the family of an individual with disabilities as well as training for professionals providing education and rehabilitation services.²⁴
- ◆ If a school district refuses to pay for AT you think your child needs, you have several options. You may decide to search out other, independent sources of funding such as Medicaid, private insurance or vocational rehabilitation. The advantage of this approach is that technology purchased with these funds will belong to the child, not the district. You can also ask the district to consider cost sharing—e.g., you buy the device and the district pays for training. Alternatively, you can ask for an IEE.

IV. B. PRIVATE AND PAROCHIAL PRIMARY AND SECONDARY SCHOOLS

If your child attends a private school, the funding options for AT are different from the options available in the public school system for children who are IDEA-eligible. Children with disabilities in private schools—with the exception of parochial schools—may be covered under Section 504 of the Rehabilitation Act, if the school receives federal financial assistance. In addition, RCW 49.60 obligates private, nonsectarian schools to provide reasonable modifications to their facilities and programs to accommodate the needs of students with disabilities.

The obligations of private schools covered by Section 504 or RCW 49.60 to provide AT to students with disabilities is generally less than under IDEA since these schools are not obligated to provide students with FAPE. Nonsectarian schools are required to provide reasonable modifications in programs and services—including supplemental aids and services—to accommodate the needs of students with disabilities, unless doing so would result in a fundamental alteration of their program or an undue burden.

An additional question for children with disabilities attending private schools is whether they are entitled to receive services from the public school system and if so, how many. If the child is enrolled in the private school by the public school district, the public school will be obligated to pay for all related costs including tuition and special-education services. The rule is very different for children enrolled in private schools by their parents. Children who attend private school have no individual right to AT and related services that the child could receive at public school.²⁵ Under the 1997 amendments to IDEA, the level of services required under federal law is limited, although states may provide more at their discretion.²⁶

Children who attend private school have the option of enrolling as part-time public school students. Additional services may be available to students enrolled in public school on a part-time basis. However, at this point, it is not clear whether the new federal limit applies to all private-school students, including those are enrolled in a part-time basis. This issue will need to be clarified over time.

Parents whose children are currently enrolled in private schools and are receiving AT and related services from their local school districts may be able to negotiate an agreement whereby the district continues to provide such services. If not, and the parents choose to keep the child in the private school, they would need to establish that the public school is not able to provide FAPE in order to obtain full funding of their child's special education and related services. Parents may be able to do this by showing that the school failed to meet the procedural or substantive requirements established in IDEA, but are likely to need qualified legal advice. For more information about private school education in general, visit the OSPI Web site (Appendix 1).

IV. C. POST-SECONDARY EDUCATION

Post-secondary education refers to education at colleges and universities as well as post-secondary vocational training. These schools are not subject to IDEA and the rules with respect to FAPE do not carry over into post-secondary education. However, both Section 504 and the ADA prohibit post-secondary educational institutions from discriminating on the basis of disability. The specific laws that apply to any particular institution depend on whether it is public or private. However, with only a few exceptions, the same principles apply under all relevant federal laws and RCW 49.60.

Generally, a post-secondary institution may not exclude an otherwise qualified student from any part of its program or services or otherwise discriminate against an applicant or student with a disability. Covered institutions must provide reasonable modifications in both academic and extra-

curricular programs and services to accommodate the needs of students with disabilities, unless such modifications would cause an undue burden or hardship, or require a fundamental alteration in the program. Examples of such accommodations include assistance with, or modifications in, services relating to: recruitment, applications, enrollment, registration, financial aid, course work and examinations, research and housing. Another example is the provision of auxiliary aids and services in order to facilitate communication with students with disabilities.

Washington law specifically describes examples of the types of accommodations post-secondary institutions should provide to students with disabilities. This list was designed to make it easier for both college administrators and students to know what kinds of assistance to expect. Services listed include:

- Sign language, oral and tactile interpreter services, or other technological alternatives
- Textbooks and other educational materials in alternative media, including, but not limited to, large print, Braille, electronic format, and audio tape
- Facilitation of physical access including, but not limited to, relocating of classes, activities, and services to accessible facilities and orientation if route of travel needs change, such as at the beginning of a quarter or semester
- Access to adaptive equipment including, but not limited to, TDDs, FM communicators, closed caption devices, amplified telephone receivers, closed circuit televisions, low-vision reading aids, player/recorders for 15/15 4-track tapes, photocopy machines able to use eleven-by-seventeen inch paper, brailling [sic] devices, and computer enhancements
- Referral to appropriate on-campus and off-campus resources, services, and agencies
- Referral to the appropriate entity for diagnostic assessment and documentation of the disability
- Notification of the institution of higher education's policy of nondiscrimination on the basis of disability and of steps the student may take if he or she believes discrimination has taken place²⁷

The obligation of the institution to pay for AT in any given situation will depend on the circumstances of each student. Institutions of higher education cannot deny provision of auxiliary aids based on the ability of the student to pay or their enrollment in specific programs. At least one federal court has held that a university must provide auxiliary aids for students with disabilities when deemed an appropriate accommodation under Section 504—even though the student is eligible for VR services.²⁸ This finding suggests that institutions cannot require students to request technical assistance or support from VR agencies.

None of these federal or state laws requires institutions of higher education to pay for “personal devices and services” including, wheelchairs, hearing aids, personal attendants or personal computers. Defining what is and what is not a personal service can be difficult in some cases (e.g., tutoring) and schools vary widely in the services they provide to students with disabilities.

Therefore, it is important to specifically find out what services will be available from the university during the application process. The school's disabled student services office can provide this information.

DISABILITY-RELATED EXPENSES AND RESOURCES

Students with disabilities often face additional expenses not incurred by other students. These include such things as special disability-related equipment and its maintenance; expenses of services for personal use or study such as readers, interpreters, note takers, or personal care attendants; alternative transportation necessary to pursue an academic program (if regular transportation is not accessible); TTY's, hearing aids, food and veterinary bills for dog guides and disability-related medical expenses not covered by insurance. Students should discuss these disability-related expenses with the school's financial aid office. Such expenses can be used to offset income for the purposes of calculating "need." They also can be considered educational expenses for which additional financial aid may be available.

FINANCIAL ASSISTANCE FROM DVR OR DSB

Assistance to students with disabilities is often provided by state VR agencies. Tuition expenses, reader services for persons who are blind or have learning disabilities and interpreter services for people who are deaf or hard of hearing are among the AT devices and services funded by DVR and DSB to students. Other examples include individually prescribed aids and devices as well as telecommunications and sensory AT devices and services. Students with disabilities who seek financial assistance should contact both the VR agency and the financial aid office of the institution they plan to attend as early as possible to determine what services (and AT) will be provided by what agency. This information should be gathered and assessed as part of the transition planning process beginning at age 16 or younger. While the institution determines the student's eligibility for student financial assistance, the VR agency will assess additional disability-related needs and award funds, as appropriate. Whatever is not covered by the VR agency can be recalculated by the institution into the student's expenses and, if funds allow, increase the student's aid. Even with excellent cooperation between the financial aid administrator and the VR counselor, there still may be unmet needs requiring additional family contribution or loans.

SOCIAL SECURITY ADMINISTRATION (SSA)

Supplemental Security Income (SSI) is a federal program set up to provide financial assistance to persons who are aged, blind, disabled and have little or no income and resources. The amount of SSI payment is dependent upon the income and resources of the client. (If a student is under 18, some of his or her parents' income and resources will be included.) A student should be aware that earnings from work-study or other work may affect SSI benefits. If the SSA approves a Plan for Achieving Self-Support (PASS), the student would be able to set aside income and resources that are being used toward a specific vocational goal (tuition, savings for equipment or other needs) and continue to receive SSI payments. Plans can be developed by the student, VR counselors, public or private social agencies and groups, or anyone else assisting the student.

The Social Security Disability Insurance (SSDI) program allows workers and eligible dependents to receive monthly cash benefits because of a period of disability. Students who have been employed may file based on their work record. If the parents of students with disabilities have filed for Social Security, or if a parent is deceased, students may also qualify for dependents' benefits based on the parent's work record. For more information on student provisions and eligibility requirements of various Social Security programs, contact your local SSA office. Information about Social Security is also available in Chapter III. More information for students with disabilities interested in going to college can be found at Web sites of The American Council on Education's HEATH Resource Center and the DO-IT program at the University of Washington (Appendix 1).

CHAPTER IV NOTES

¹ Washington Administrative Code (WAC) 392-172. Washington Special Education regulations have been revised and are being considered for permanent adoption.

² 20 United States Code (U.S.C.) § 1401 (25); WAC 392-172-035(1).

³ 16 Individuals with Disabilities Education Law Reporter (IDELR) 1317 (1990) Policy letter.

⁴ WAC 392-172-070.

⁵ WAC 392-172-065.

⁶ Id.

⁷ Other “special factors” which must be addressed by the IEP team include: (i) in the case of a child whose behavior impedes learning, the strategies and supports needed to address that behavior; (ii) the language needs of children with limited English proficiency; (iii) in the case of a child who is blind or visually impaired, the need for Braille instruction and (iv) in the case of a child who is deaf or hard of hearing, the child’s communication needs. 20 U.S.C §1414(d)(3)(B)(i-iv).

⁸ Washington’s Office of the Superintendent of Public Instruction (OSPI) has added a line in the IEP to cover this requirement.

⁹ 34 Code of Federal Regulations (C.F.R.) §300.344(6).

¹⁰ See Office for Special Education Programs (OSEP) Policy Letter dated 4/14/92, 18 IDELR 1039 (1992). IEP should include specific statement as to amount, nature of the AT services to be provided.

¹¹ WAC 392-172-150 states that parents may request an IEE at public expense if the parent disagrees with the district’s evaluation results.

¹² 23 IDELR 565 (December 4, 1995).

¹³ WAC 392-172-150-3(4)(b).

¹⁴ 20 U.S.C. §1401(a)(19)(20); 34 C.F.R. 300.346.

¹⁵ 20 U.S.C. §1414(d)vii(I); 34 CFR §300.29.

¹⁶ 34 C.F.R. §104.33.

¹⁷ 28 C.F.R. §35.135.

¹⁸ WAC 162-26-080.

¹⁹ Revised Code of Washington (RCW) 74.09.5241 *et. seq.*

²⁰ 20 IDELR 1067 (August 9, 1994).

²¹ 20 IDELR 216 (November 19, 1993).

²² 34 C.F.R. §300.301 (a)-(c).

²³ 34 C.F.R. §300.532(g).

²⁴ 20 U.S.C. §1401 (1) (2); WAC 392-172-070.

²⁵ 34 C.F.R. §300.454.

²⁶ 34 C.F.R. §300.453 (a)(d).

²⁷ RCW 28B.10.912.

²⁸ *US v. Board of Trustees for University of Alabama*, 908 F.2d 740, 745 (11th Cir. 1990).

CHAPTER V

ASSISTIVE TECHNOLOGY FUNDING FOR SPECIAL POPULATIONS

AT funding is available through various programs that serve people with specific types of disabilities or individuals who meet specific criteria based on their age or past military service. Many of the previously discussed funding sources may also be available to individuals included in these “special populations.” As noted earlier, it is often best to pursue more than one source of funding to expedite funding and acquisition of AT. Keep in mind that there is often a debate between agencies as to who is responsible for providing AT services and devices. You may need to actively encourage cooperation between agencies to be sure you get the AT you need. WATA is available to assist if you run into difficulties.

V. A. EARLY INTERVENTION SERVICES: PART C OF THE IDEA

Part C, formerly Part H, was added to IDEA in 1986 to expand access to early intervention/family services for children with disabilities from birth to 3 years old. Children 3 and older are served under Part B of IDEA. Part C was designed to provide coordinated service delivery to infants, toddlers and their families and to fill gaps in existing services as needed.

In Washington, the Department of Social and Health Services Infant Toddler Early Intervention Program (ITEIP) is operated within the Division of Developmental Disabilities. ITEIP directs and coordinates a statewide system of early intervention services through its contracts with various local agencies—such as school districts, neuro-developmental centers and local health departments. Family Resource Coordinators are assigned to each county to work directly with children with disabilities and their families.

To be eligible for early intervention services in Washington, a child must have a 25% of chronological age delay or show a delay 1.5 standard deviations below the mean for his or her age in one or more developmental areas. A child may also be eligible if he or she has a physical or mental condition that is known to cause a delay in development. The family focus is of utmost importance in Part C and, under the law, all children enrolled in Part C programs must have an Individualized Family Service Plan (IFSP). This plan is developed in partnership with families, a family resources coordinator and other service providers. Each IFSP includes specific developmental outcomes for the child and family, describes strategies to achieve those outcomes and identifies resources to implement the strategies.

Services available to children under Part C as “early intervention services” are varied and include, among others, special education, physical therapy, nutrition services, audiology, nursing services, speech-language pathology, family training, counseling and home visits, vision services and AT. However, Part C programs are payors of last resort—meaning that Part C will only fund devices and services if the family has exhausted all other possible sources of funding including Medicaid and private insurance. Family resource coordinators assist families in identifying and pursuing such funding sources.

Many infants and toddlers can benefit from AT to develop communication, perceptual and fine motor skills as well as improved mobility. AT assessments are critical in selecting appropriate technology and should be conducted by qualified professionals as part of a developmental assessment team. It is particularly important to recognize that infants and young children are developing quickly and their needs may change rapidly. Assessments for AT needs should be considered an on-going process. The AT assessment should consider the following:

- Developmental needs and functioning of the child
- Equipment and device options
- Needs of family and the child
- Use of equipment
- Proper prescription for a device
- Current needs
- Use of loan equipment
- Training for child and family¹

For more information about ITEIP, call the “Healthy Mothers, Healthy Babies” hotline (Appendix 1), which maintains current information on public and private early intervention resources as well as other children’s health services available in Washington.

V. B. PERSONS WITH DEVELOPMENTAL DISABILITIES

The Division of Developmental Disabilities (DDD), a part of the DSHS, is responsible for providing services to persons with developmental disabilities. To be eligible for services from DDD, you must have a developmental disability as defined by law. A developmental disability is a condition that meets all of the following criteria:

- a) A condition defined as mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition . . .;
- b) Originates before the individual reaches eighteen years of age;
- c) Is expected to continue indefinitely; and
- d) Results in a substantial handicap.²

Applications for DDD services can be made at local DDD offices.

By law, DDD is directed to serve the best interests of its clients—it is empowered to provide individual client centered benefits designed to prevent regression or loss of skills already acquired, achieve or maintain economic self-support, achieve or maintain self-sufficiency.³ DDD is required to develop a written individual service plan (ISP) or similar planning document for each eligible person. The ISP provides an assessment of a person’s habilitation needs and identifies services to meet those needs.⁴ Such needs may include AT and, if so, the ISP should specify what types of AT and related services should be provided—a determination that often requires an AT assessment. The parents or guardians of the client, the client him or herself and any advocate as

well as the representatives of the agency primarily responsible for providing specific provisions of the plan, should participate in developing the ISP.

DDD does not provide any “direct” or explicit funding for AT. However, AT can be provided by the family support services program, which is intended to help families who are caring for individuals with developmental disabilities in their homes.⁵ The goal of this funding is to make it possible for individuals with developmental disabilities to live in the community rather than institutions. Family support funding can be used for a variety of purposes including but not limited to:

- Therapeutic services
- Physical therapy
- Occupational therapy
- Communication therapy
- Specialized equipment and supplies including the purchase, rental, loan or refurbishment of specialized equipment or adaptive equipment. Mobility devices such as walkers and wheelchairs are included, as well as communication devices.
- Environmental modification including home repairs for damages, and modifications to the home needed because of the disability of the client.⁶

DDD also provides funding for individual support services that assist persons with developmental disabilities to be independent, productive and integrated into their communities. These supports can include personal assistance services, AT, vehicle and home modifications, support at work, and transportation.

Children with developmental disabilities may also obtain AT funding through the DD Cap Waiver. Through this waiver program, children with developmental disabilities receive expanded access to Medicaid. Under the waiver, the Medical Assistance Administration (MAA) determines Medicaid eligibility solely on the basis of the child’s income and resources rather than on the basis of family income and resources. The Medicaid DD CAP Waiver is an important resource for many low- to moderate-income families. For more information about the DD CAP Waiver, contact your DDD case manager or local community service office.

V. C. VETERANS

The Veterans Administration (VA) provides a variety of benefits to individuals who have served in the United States military. Veterans who leave active military service with an honorable or general discharge are eligible for VA benefits.⁷ Active service generally means full-time service as a member of the Army, Navy, Air Force, Marines, Coast Guard, or as a commissioned officer of the Public Health Service, the Environmental Services Administration, or the National Oceanic and Atmospheric Administration.

Eligible veterans have access to a wide variety of AT devices and services through the VA. Some examples of VA benefits with an AT component include:

- VA may purchase adaptive equipment for a vehicle or provide up to \$5,500 towards the purchase of a vehicle, or other conveyance. Veterans may also be reimbursed for repairs and adaptive equipment purchased independently, subject to certain caps. To apply, contact a VA regional office or the prosthetic office at a VA medical center and ask for the “Application for Automobile or Other Conveyance and Adaptive Equipment.”
- Veterans who participate in a rehabilitation program may receive AT such as prosthetic appliances, eyeglasses, telecommunications, sensory and other corrective or assistive devices. Ask the local VA regional office for the “Disabled Veterans Application for Vocational Rehabilitation.”
- Additional special equipment necessary for participation in a rehabilitation program may be provided, including the following:
 - * Equipment for educational or vocational purposes such as calculators with speech capability for people who are blind and other equipment ordinarily used by people without disabilities.
 - * Modifications to improve access to programs including adaptive equipment for vehicles or adaptations or supplies to make a veteran's home useful for training or self-employment.
- Other incidental goods and services may be provided at the case manager's discretion, if necessary to implement the rehabilitation plan.
- Veterans may apply for prosthetic services to treat any condition when receiving outpatient, hospital, domiciliary, or nursing-home care in a VA facility. Prosthetic aids include artificial limbs, braces, orthopedic shoes, hearing aids, wheelchairs, medical accessories and similar appliances including, lifts and therapeutic and rehabilitative devices.
- VA will pay for repairs to artificial limbs, trusses, braces, hearing aids, eyeglasses, or similar appliances reasonably damaged or destroyed in an incident related to the service-connected disability. VA will pay for repairs to prosthetic or similar appliances, therapeutic aids, or devices when necessary and when the cost is reasonable. VA will also pay for fitting and training in the use of prosthetic and similar appliances.
- AT for veterans who are blind includes low-vision aids, and training in their use; approved electronic and mechanical aids for the blind; their necessary repair and replacement, and talking books, tapes and Braille literature from the Library of Congress.

- VA may supply lifts to veterans who have experienced loss, or loss of use, of both lower extremities and at least one upper extremity; have been medically determined incapable of moving to and from bed and wheelchair without the aid of an attendant; and when a lift has been determined to be a medically necessary and feasible means to accomplish the necessary maneuvers between a bed and wheelchair.
- VA may provide other therapeutic and rehabilitative devices (including medical equipment and supplies) if the device, equipment or item supplied is determined medically necessary and is of the type available as medical equipment.
- Any veteran who is profoundly deaf (rated 80% or more disabled for hearing impairment by VA) and is entitled to compensation on account of the hearing impairment may be provided assistive listening devices, including telecaptioning television decoders.
- VA offers a one-time grant (up to \$38,000) of not more than 50% of the cost of building, buying or remodeling adapted homes, or paying off debt on homes already acquired. For more information on specially adapted housing, ask the local VA regional office for the brochure "Questions and Answers on Specially Adapted Housing and Special Housing Adaptations for Veterans."
- A one-time grant of up to \$6,500 for special housing adaptations that the VA determines to be reasonably necessary may be provided. Loans or a loan guarantee, to supplement a grant for a specially adapted home or to purchase adaptations may also be available.
- Some veterans may be eligible for home improvements and structural alterations through the Home Improvements and Structural Alterations (HISA) program, which will pay for improvements necessary for the continuation of treatment or to provide access to the home and essential lavatory and sanitary facilities.

These and other programs offered through the VA have varying eligibility rules. Some programs are available only if you have served in specific wars; others are available only if you were injured during active service. Check for details of eligibility with the local VA regional office.

Those filing a claim with the VA for the first time must submit a copy of their service discharge form (the DD 214) that documents service dates and type of discharge, or give their full name, military service number, branch of service and dates of service. Veterans may apply for benefits in various places, depending on the type of benefits. Contact information for Washington state is available in Appendix 1.

V. D. TRICARE (FORMERLY CIVILIAN HEALTH & MEDICAL PROGRAM OF THE UNIFORMED SERVICES OR CHAMPUS)

Until a few years ago, the federal program designed to pay the costs of civilian health care for dependents of active-duty military and their families, retirees and their families and survivors of

all uniformed services who were not eligible for Medicare, was known as CHAMPUS. CHAMPUS is now called TRICARE Standard in most of the country; it is one part of the new TRICARE health benefits program of the Department of Defense.

TRICARE offers families three choices:

- 1) Enrollment in TRICARE Prime, a health maintenance organization (HMO)-type source of care with low costs;
- 2) TRICARE Standard is a fee-for-service option, which is the same as CHAMPUS, with the same benefits and cost-sharing structure; and
- 3) TRICARE Extra, which is similar to TRICARE Standard but is an expanded network of providers that offers reduced cost-sharing, doesn't require enrollment, and can be used on a case-by-case basis.

Each of the options differs in aspects such as deductions and other costs related to coverage, which makes generalizations difficult. However, the coverage for AT as described below is similar in each option.

For more information about any of the three TRICARE options, contact your regional contractor's nearest TRICARE service center; or call the health benefits adviser at the nearest military medical facility (Appendix 1).

Each of the TRICARE coverage options has different amounts of coverage and benefits, although the types of benefits are the same. TRICARE covers the rental or purchase of medically necessary DME such as wheelchairs, hospital beds, oxygen and respirators, if prescribed by the attending physician. "Medically necessary" is defined by federal regulation as services or supplies provided by a hospital, physician or other provider for the prevention, diagnosis and treatment of an illness, when those services or supplies are determined to be:

- Based on generally accepted current medical practice;
- Consistent with the condition, illness or injury of the patient;
- Provided in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered;
- Not primarily for the convenience of the patient, physician or other provider;
- Appropriate treatment for the covered person's diagnosis or symptoms; and
- Not exceeding (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment.

The services and equipment covered by TRICARE under DME are defined as:

- Equipment for which the allowable charge is over \$100;
- Is medically necessary for the treatment of a covered illness or injury;

- Improves the function of a malformed, diseased or injured body part or retards further deterioration of the patient's physical condition;
- Is used primarily and customarily to serve a medical purpose, rather than primarily for transportation, comfort or convenience;
- Can withstand repeated use;
- Provides the medically appropriate level of performance and quality for the medical condition present (that is, "nonluxury and nondeluxe");
- Is other than spectacles, eyeglasses, contact lenses or other optical devices, hearing aids or other communication devices; and
- Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools or other such items.⁸

TRICARE allows coverage for a variety of AT devices and services if the beneficiary can support the medical necessity of the devices or services. In addition, under the Program for Persons with Disabilities, a training benefit that includes the use of AT devices is allowed. This financial assistance program can be used in conjunction with TRICARE benefits.⁹ Information on coverage of AT through TRICARE is available on the Web (Appendix 1).

V. E. LONG-TERM RESIDENTIAL CARE FACILITIES

Federal and state laws govern the operation and services provided to individuals living in long-term care residential facilities. These laws provide residents of long-term care facilities with rights of access to AT. The following brief summary of these rights is relevant to residents of adult family homes, assisted living settings, boarding homes, nursing homes and Intermediate Care Facilities (ICF) for individuals with developmental disabilities. More information about the provision of AT in these settings can be obtained from the Aging and Adult Services Administration (Appendix 1).

RIGHTS TO AT UNDER NONDISCRIMINATION LAWS

Most long-term residential care facilities are places of public accommodation subject to the ADA and the state Law Against Discrimination, RCW 49.60. These civil rights laws prohibit places of public accommodation from discriminating against individuals with disabilities. They also require public accommodations to provide reasonable modifications in their programs and services in order to accommodate the needs of individuals with disabilities, specifically including auxiliary aids and services. Examples of "auxiliary" aids and services are listed in the federal regulations implementing Title III of the ADA. They include:

- Qualified interpreters, notetakers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices and systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDDs), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;

- Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually-delivered materials available to individuals with visual impairments;
- Acquisition or modification of equipment or devices; and
- Other similar services and actions.

Places of public accommodation do not need to make modifications or provide auxiliary aids and services if doing so would cause undue burden (i.e., involve significant burden or expense) or fundamentally alter the nature of the program provided. The nondiscrimination laws also do not require places of public accommodation to provide devices or services of a “personal” nature hearing aids.

A wide range of AT is available that can benefit individuals living in residential care facilities. Much of this AT is low cost and “light tech” such as adaptive cooking and eating utensils and dishes, portable FM devices, remote controls, grabbers and reachers for individuals with mobility constraints, dressing aids and magnifying lenses. Some of it (e.g., adaptive computer technology, CCTVs) is more expensive but can be shared and used by many residents to enrich and improve their lives—as well as their ability to function independently. The ADA and state laws against discrimination provide a basis for requesting such AT as a reasonable accommodation.

RIGHTS TO AT UNDER OTHER LAWS

Long-term care facilities are regulated by DSHS, which has adopted separate administrative rules for each type of facility. These administrative rules establish guidelines for licensing and operation; they also identify and list the basic rights of residents. Copies of these rules are available from DSHS (Appendix 1).

Some long-term care facilities, such as nursing homes, are also subject to specific federal laws and regulations. Nursing homes that do not comply with these laws and regulations are not allowed to admit Medicaid clients. Washington state law requires all nursing homes to follow these federal guidelines—including those guidelines that define the rights of nursing home residents. Washington law also extends these same rights to other long-term care residents including those living in veterans' homes, boarding homes, adult family homes, assisted living facilities and ICF/MR.¹⁰

These regulations require that each resident be provided with care based on a systematic, comprehensive, interdisciplinary assessment and care planning process in which the resident actively participates.¹¹ This plan is to be based upon an initial assessment of each resident's functional capabilities and ability to perform activities of daily living. This assessment must be completed within 14 days of admission and updated annually or promptly after any significant change in condition.¹²

Residential care facilities must use this assessment to develop a comprehensive care plan for each resident. The plan of care must include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive

assessment.¹³ The plan of care should be guided by the standard of care applied to residential long-term care—each resident is entitled to receive the “necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, self-care and independence in accordance with comprehensive assessment and plan of care.”¹⁴ Long-term care facilities are also required to “ensure” that a resident’s abilities in activities of daily living do not diminish unless the medical condition of the resident is such that it is unavoidable. Activities of daily living include the abilities to:

- Bathe, dress and groom
- Transfer and ambulate
- Toilet
- Eat
- Use speech, language or other functional communication systems

Residents who are unable to carry out these activities of daily living must receive “appropriate treatment” to improve their abilities with respect to these specific aspects of daily living. Appropriate care and services also must be provided with respect to a list of other specific areas of need including, vision and hearing, prostheses, and independent living skills.¹⁵ These regulations provide long-term care residents with a strong entitlement to AT devices and services (including AT assessments) where needed to maintain or enhance functional capabilities.

Many patients (and families) are unaware of their rights and unfamiliar with the types of AT available to assist them. Many residential care providers likewise do not have the expertise needed to meaningfully incorporate AT into the services they provide. Medicaid regulations currently provide that medical equipment will be paid for separately if the equipment is necessary for the continuous care of the patient or to meet the unusual medical needs of that patient. Thus, whether the AT is paid for by the facility or by Medicaid as a separate item depends on whether the AT is appropriate for use by a particular resident or is intended for use by many different residents. For example, Medicaid should pay for a wheelchair with customized cushioning or an augmentative communication device that requires individualized programming. Whereas, a standard wheelchair with no customized cushioning or a low-level communication device with a few pre-programmed messages should be covered by the residential care facility.

To enforce residential rights to AT, residents and/or their families should insist that the AT be considered as a component of the assessment and comprehensive care plan development. In many cases, this will require the assistance of an outside consultant—an occupational therapist, a physical therapist, a speech-language pathologist or another expert with training in AT. It will also likely require continued advocacy on the part of the patient’s family to ensure that the AT is purchased and used with proper training to staff, family and the resident.

CHAPTER V NOTES

¹ *First Steps Assistive Technology System: A Collaborate Effort Between First Steps and Kentucky Assistive Technology Service (KATS) Network.* (Summer 1996) p 5-6.

² Washington Administrative Code (WAC) 275-27-026.

³ WAC 275-27-020.

⁴ WAC 275-27-060.

⁵ WAC 275-27-220.

⁶ WAC 275-27-220 (2).

⁷ 38 Code of Federal Regulations (C.F.R.) § 3.1(d).

⁸ TRICARE/CHAMPUS Policy Manual 6010.47.M (June 25, 1999) Chapter 7, §3.1.

⁹ TRICARE/CHAMPUS Policy Manual 6010.47.M (June 25, 1999) Chapter 8, §1.10.

¹⁰ Revised Code of Washington (RCW) 70.129.005 *et seq.*; WAC 388-78A (boarding homes); WAC 388-110-067(assisted living facilities); WAC 388-76 (adult family homes); WAC 275-38-005(ICF's).

¹¹ WAC 388-97-090.

¹² WAC 388-97-085.

¹³ WAC 388-97-090.

¹⁴ WAC 388-97-110(2).

¹⁵ WAC 388-97-110(4).

CHAPTER VI

WHAT TO DO WHEN ASSISTIVE TECHNOLOGY FUNDING IS DENIED: AVENUES OF APPEAL

Unfortunately, many requests for funding AT are denied. Although it can be incredibly frustrating if your first or second request is rejected, don't give up. All funding agencies have appeal processes and many people have been successful in getting what they need on appeal. As with the original request, you will need to become familiar with the agency's funding criteria, follow their procedures explicitly and be patient, but diligent. Pay particular attention to deadlines—you don't want to lose your appeal simply because you missed a deadline.

This chapter provides basic information on how to appeal denials of requests for funding AT. We have tried to provide enough information to get you started, but not so much that you get lost in the details. Remember that rules and procedures change. Make sure to identify the most current rules and procedures and follow them exactly.

The information provided here is not a substitute for legal advice. If you want to talk to an attorney, please call or write WATA, or contact an agency or attorney listed on the Washington Disability Law resource list (Appendix 1).

VI. A. HEALTH-RELATED SOURCES OF FUNDING

PRIVATE HEALTH INSURERS/HMOs

If you are denied coverage by your private health insurer and you believe that the policy provides coverage, don't be afraid to appeal. Most insurance companies have several levels of appeal. Start the process by calling or writing the person who signed the letter of denial and request copies of any documents that describe your rights of appeal. Carefully follow the deadlines and procedures outlined in those documents. If necessary provide additional documentation to support your request. The insurance company should respond to your request within the time limits stated in the description of the appeals process. The appeal is generally informal and you may have the right to appear before an appeal committee in person. If you do, take advantage of the opportunity to explain how the AT will make a difference in your life.

In preparing your appeal, look closely at the written denial from the insurer to determine why coverage was denied. Often, the reason given will be vague—a statement such as, “this device is not covered.” Call or write the patient representative to request more information. Ask why he or she thinks the item is not covered and where the reason is stated in the policy. If the request is denied because another public or private insurer is “primary,” ask why the other insurer is considered primary. Review the initial documentation supporting your AT request to make sure all of the criteria in the policy have been addressed. If not, amend your request and appeal the initial decision. You may have only 30 days to make the appeal, so it is important to act in a timely fashion.

In the letter of appeal, directly address the basis for the denial with additional documentation as appropriate. If the device is denied because another public or private insurer is primary, provide evidence of a denial from the other insurer or evidence that the other insurer does not cover such equipment. If the device is denied as “not medically necessary,” address the ways in which the device serves to maintain or enhance function. If the device is denied as “not a covered item,” address the reasons why the equipment qualifies as DME, prosthetics or orthotics under the definitions in the policy. One effective technique is to include a declaration from the vendor listing or describing the other public and private insurers that pay for these devices or documentation that the insurer has purchased similar devices in the past. WATA can provide you with copies of any applicable case law.

If a court is ultimately asked to interpret the scope of benefits, ambiguities in a policy will often be resolved in favor of the beneficiary because health insurance policies are written by the plan provider and not negotiated with the beneficiary. Therefore, it can be worthwhile to specifically point out portions of the policy or summary plan description that could be interpreted to cover AT. Including this type of information in your letter may help persuade a provider to cover the AT, even when the requested device or equipment is not specifically mentioned in the policy.

If the policy clearly does not cover the AT or DME, it may still be possible to obtain the AT from the insurer by showing that it would be less costly to pay for the AT than to pay for a covered service. For example, if the policy covers home nursing care, and the AT would allow the insurer to limit such visits, then the insurer may decide that it is cost effective over the long-term to cover the device as an exception to policy. The same logic applies when the AT is not covered but would prevent further deterioration and/or subsequent costly hospitalizations. In such cases, the insurance company may be willing to pay for all or part of the AT as an exception to policy.

Arbitration or Mediation

You may be required to engage in arbitration, depending on the policy language. In such an instance, your arguments will be presented to a neutral third party who will listen to both sides and then issue a decision. The decision of the arbitrator is usually binding upon both the parties with only limited rights of appeal. Each party pays one-half the fee of the arbitrator.

Mediation is another dispute resolution option that is often available. In mediation the mediator tries to facilitate an agreement between you and the insurance company. There is no requirement that either party agrees to settle. If an agreement is not reached, the parties are free to pursue other remedies. Again, each party pays one-half the mediation fees.

Complaint to the Office of the Insurance Commissioner

Alternatively, or in addition to appeals through the insurance company, you can file a complaint with the Washington State Office of the Insurance Commissioner (Appendix 1). The Insurance Commissioner will write a letter to the insurance company asking them to explain their position.

The insurance company has 15 days to respond and if they do not respond in a timely manner, they can be subject to legal sanctions.

This option can be very effective; however, it is only available for policies regulated by the state. It is not an option for policies issued by the state or federal government or “self-insurers.”

Hiring an Attorney

You can also hire an attorney and file a claim in state or federal court for such causes of action as breach of contract, bad faith, unfair and deceptive practices or advertising.¹ Remember that litigation can take years. If you decide to take your complaint to court, it is important to hire an attorney who is familiar with health-insurance claims. WATA can assist you in locating such an attorney.

MEDICAID²

A Medicaid recipient has the right to challenge any decision Medicaid makes or doesn't make. Such a decision might be denying the request for purchase of DME, denying the repair or servicing of a device, or refusing to continue rental of equipment. To appeal any Medicaid decision, you must request a fair hearing.

In a fair hearing, a recipient can challenge Medicaid's actions in any or all of the following areas:

- Refusal to process or delay in processing your Medicaid application
- Determination that you are not eligible for Medicaid or are no longer eligible for Medicaid
- Denial of a prior authorization request (review your initial request to see if instead of appealing you want to resubmit with more complete documentation)
- Termination of a service such as medical transportation

In the description of the appeals process below, we are using a denial of DME as an example to explain how the process works. The same process would be followed for any type of Medicaid denial.

Request a Fair Hearing

To request a fair hearing, fill out a DSHS hearing request form and turn it in to your local community service office or mail it to the Office of Administrative Hearings (Appendix 1). You may also request a hearing by phone, and send in a written request later. Your request for fair hearing must be made within 90 days of the date of the denial notice. DSHS will send you a written notice by mail, setting the date and time of the fair hearing.

At the fair hearing, an administrative law judge (ALJ) decides whether DSHS made the correct decision. The judge is an employee of the Office of Administrative Hearings and not an employee of DSHS. DSHS will be represented by an employee—usually the “fair hearing coordinator.”

Preparing for the Hearing

In preparing for the Fair Hearing, the first step is to determine why the request was denied. If, for example, the letter of denial from Medicaid states that the AT was not “medically necessary,” you will need to show the judge at the hearing why this decision is not correct and why the requested medical equipment is medically necessary. You should try to get documents that help prove your case. In particular, you should provide statements from your doctor or health care provider that describe your health condition. Ask your doctor and health care providers for help in gathering this information. Statements from doctors, nurses, and therapists are very useful if they specifically state why the medical equipment is medically necessary with reference to the words that define medical necessity. These statements should also explain why any equipment DSHS says is just as effective and less costly does not meet your needs.

Settling the Case Before a Hearing

You may be able to convince DSHS to approve your AT request before the hearing if you supply them with the additional documents you have collected which show why the AT you requested is medically necessary. As soon as possible, send copies of these documents to the fair hearing coordinator for the Medical Assistance Administration (MAA), the division of DSHS that makes decisions on medical equipment, along with a letter asking the fair hearing coordinator to tell you what specific concerns DSHS has about your case. Let the fair hearing coordinator know you want to resolve the matter without a hearing. If the fair hearing coordinator does not respond within a few days, call him or her. Contact information for the fair hearing coordinator is available in Appendix 1.

You may wish to request a pre-hearing conference with the judge if, after talking to the fair hearing coordinator, you still do not understand why DSHS denied your request. A pre-hearing conference is held by phone between you, the ALJ, and the fair hearing coordinator. At the pre-hearing conference, ask the judge to: 1) order DSHS to give you the specific reasons DSHS is denying the medical equipment you requested, and 2) prohibit DSHS from raising new arguments at the hearing.

To schedule a pre-hearing conference, contact the fair hearing coordinator first, and then let the Office of Administrative Hearings know you would like to schedule one (Appendix 1). The Office of Administrative Hearings will arrange a time that is convenient for all parties.

DSHS may ask you to get a second opinion from a doctor and/or equipment supplier concerning whether the DME you requested is medically necessary. You can go to a doctor or equipment supplier chosen by DSHS, or you may get the second opinion from a doctor or equipment supplier you choose yourself.

The Fair Hearing

Fair hearings are informal. They are usually held at your local welfare office or may even be held by a telephone conference call. The judge knows nothing about your case before the hearing begins, unless you've had a pre-hearing conference and will decide the case based upon the information provided at the hearing. You may bring people with you to testify in support of your arguments—i.e., to be witnesses for you. You may also bring a friend, relative, or person to represent you. The hearings are tape recorded to make a record of everything that is said. All those planning to testify will be asked to take an oath swearing that what they say is the truth.

Give copies of all the documents you have collected in support of your case to both the judge and the fair hearing coordinator at the beginning of the hearing. When the hearing starts, the fair hearing coordinator will explain why DSHS believes the requested AT is not medically necessary. Sometimes a DSHS employee such as a DSHS consulting doctor will be a witness for DSHS. You will have a chance to ask the fair hearing coordinator and other witnesses questions after the fair hearing coordinator has presented the DSHS position.

You will then have the chance to explain why the AT is medically necessary and have your witnesses testify for you. Tell the judge everything that you feel is important to your case. We suggest that you make a list of what you want to say before going into the hearing. At the end of the hearing, when the judge asks if you have anything else to present, you can check your list to make sure you have covered everything.

The fair hearing coordinator has the right to ask you and your witnesses questions once you have completed your presentation. The judge may ask you questions as well. If you think DSHS violated a law or regulation, make sure to tell the judge which one(s). If DSHS presents an argument that you feel you and your witnesses cannot respond to without asking for help from your doctor or equipment provider, ask the judge for time to get a written response. When you get the information, mail copies of the response to the judge and to the fair hearing coordinator.

The judge will not give the decision at the hearing. You will get a written response in the mail about three weeks after the fair hearing.

Right to Appeal ALJ Decisions

The ALJ's decision can be appealed by either you or DSHS to a review judge employed by DSHS. The appeal must be filed within 21 days of the date that the initial decision was mailed. The appeal is called a petition for review. The instructions for filing the petition for review should be explained on the last page of the ALJ's decision.

The review judge reviews the petition for review and the case file. There is no additional hearing to attend. The review judge must mail a written decision to the consumer and the fair hearing coordinator. If you disagree with the review decision, you may appeal it to superior court.

Additional Appeals Options for Healthy Options

Healthy Options, the Medicaid managed-care program offered through DSHS has several additional options for consumers who are dissatisfied with a decision from the provider. These include contacting the plan's consumer advocate or representative who may be able to resolve the problem. The phone number of that person or office should be on the back on your plan card. If the consumer advocate or representative still cannot help you, you can file a grievance. It is highly recommended that you file a grievance in writing although Healthy Options providers are required to accept oral grievances also. Your plan policy should provide you with specific instructions on grievance procedures. You should follow these exactly, but also be sure that you explain the reason for your grievance. The Healthy Options Hotline or Client Advocate are also available to help resolve complaints and hear about problems with plans (Appendix 1). If you continue to be dissatisfied, the other rights to a fair hearing and appeal described above also apply to you.

MEDICARE

Appeals under Medicare differ depending on whether you are appealing a decision under Part A or Part B. Although most AT will be funded under Part B, we provide general information about Part A also.

Part A Appeal Process

While Part A generally covers institutionalized care, DME or prosthetics may be requested as part of inpatient services while an individual is in an institution. If Medicare Part A coverage for a requested device or service is denied, the first step in the appeal process is to request a reconsideration by the private insurance organization (carrier) that handles the Part A claims for Medicare. Reconsideration must be requested within 60 days of an initial denial, unless there is good cause for failing to do so. The reconsideration consists of a review of the case file (including any written arguments or additional evidence the beneficiary chooses to submit) by an employee of the intermediary who did not participate in the original decision.

If you are dissatisfied with the reconsideration decision by the carrier, and if the amount in controversy exceeds \$100, you have 60 days to ask for an administrative hearing. Under Part A, these hearings are conducted by an ALJ employed by the Social Security Administration (SSA). The ALJ will assist you in presenting your case, although it is always advisable to have an attorney or advocate at this stage if possible. ALJs are not bound by HCFA's policies and can ignore them if the policies appear to conflict with the statutes or regulations.

If the hearing decision is unfavorable, you have 60 days to request a review by the Social Security Appeals Council. Additional evidence may be submitted to the Appeals Council. Generally, the Appeals Council is concerned with whether there are errors in the ALJ's decision such as a misinterpretation of the law. You have the right to file an appeal of unfavorable Appeals Council decisions in federal court.³ The case must be filed within 60 days of the Appeals Council decision, and there must be at least \$1,000 in controversy.

Part B Appeal Process

Under Part B, once your Medicare claim is determined you will receive an Explanation of Medicare Benefits (EOMB) form, which states the carrier's decision. The statement on the form should provide you with information concerning the reason for the decision and the calculation the carrier used to arrive at the amount it has determined you are responsible to pay towards the AT. The form is often unclear and may not fully explain why a claim was denied or reduced. Each carrier has a toll free telephone number, listed on the back of the EOMB form that you can call for an explanation of the decision and what additional information might change the outcome.

You have the right to ask the carrier to perform a file review. This review can be requested up to six months after the initial decision (later if good cause can be demonstrated).⁴ Some examples of good cause for late filing of an appeal include the beneficiary's serious illness that prevented attention to personal business, the beneficiary's failure to understand the appeal requirements, or the beneficiary's lack of receipt of the EOMB form and notice of appeal rights.

The review is initiated by completing a Request For Review of Part B Medicare Claim form. Most sections of the form are self-explanatory. You should, if possible, also submit additional documentation from a physician or supplier explaining why the equipment is medically necessary and reasonable. Remember to keep the original of the documents and submit a copy. The form can be submitted to the carrier or to a local Social Security office. This review is performed by a different carrier employee than the one who made the initial determination.

The next step in a Part B appeal is a hearing. The request for a hearing must be filed with the carrier within six months of the review decision and the amount in dispute must be \$100 or more.⁵ Claims over any six-month period can be added together to reach the \$100 minimum. You have the right to a face-to-face meeting or you can participate by phone. The hearing officers for Part B claims are employees of the carriers. They must apply HCFA policies and rules as if they were law, even if they appear to conflict with Medicare statutes and regulations. Although it is a lot of work to go through a hearing, it is often worthwhile to do so. Almost 50% of appeal hearing decisions result in additional benefits for the claimant.

Part B claimants who are not satisfied with the result of the hearing conducted by the carrier hearing officers and who have \$500 or more in controversy can ask for a hearing with an ALJ employed by the SSA. The amount in controversy can be on one person's single claim, several claims added together by the same person, or the sum of several claims by different people if there are common issues. It takes several months to obtain a Part B hearing, but if you are willing to submit the case to the carrier's hearing officer without asking for an ALJ hearing to be held, the process will move faster. The decision to do so is a tactical one that will depend on the facts of an individual case. In many instances, it is advisable to wait for an ALJ hearing. As with Medicaid appeals, if you determine it is time to go to court, be sure that you have some assistance from a knowledgeable attorney.

If not satisfied with the result of a hearing by an ALJ, Part B recipients with \$1,000 or more in controversy have the right to file a complaint in federal district court requesting a review of their claim.

WASHINGTON STATE BASIC HEALTH PLAN

Members who want to appeal an AT decision from a Basic Health Plan provider should refer to their Basic Health Member Handbook for the specific procedures. The handbook is also available on the Web (Appendix 1).

VI. B. EMPLOYMENT-RELATED SOURCES OF AT FUNDING

PUBLIC AND PRIVATE EMPLOYERS

If you believe that an employer has failed to provide a reasonable accommodation or otherwise discriminated against you, a complaint can be pursued in a variety of ways, depending on the applicable law. Under the ADA, individuals must file a complaint with the Equal Employment Opportunity Commission (EEOC) before they can file a complaint in court.⁶ A complaint must be filed with the EEOC within 180 days—or in some situations 300 days—of the discrimination.⁷ The EEOC will investigate and depending on whether it finds evidence of discrimination will issue a “cause” or “no cause” finding. Once it has made a finding, or sooner if the complainant requests it, the EEOC will issue a “right to sue” letter giving the complainant the right to sue in federal court. Once the letter is issued, employees have 90 days to file a complaint.⁸

Under Section 501 of the Rehabilitation Act, federal-agency employees must consult with their agency’s Equal Employment Opportunity (EEO) counselor before submitting a complaint to the EEOC. This must be done within 45 days of the incident of discrimination.⁹ If the situation is not resolved to the satisfaction of both parties after informal counseling, the EEO counselor will give written notice of the decision, which allows the employee to file a formal complaint with the employer within 15 days.¹⁰ The employer then makes a formal and final decision. The employee has 90 days to appeal that decision to the EEOC. A complaint must first be filed with the EEOC before filing in court.

Employees of institutions or agencies that receive federal grants have several options in filing complaints. They can file a complaint with the federal agency that gives funds to the grantee. Each federal agency is responsible for its own regulations regarding complaints under Section 504. Although most agencies have similar regulations and allow 180 days to file, it would be wise to confirm this with the agency before filing a complaint. However, complaints do not need to be filed with the federal agency before going to court. You can choose to skip the administrative complaint process and go straight to court. You can file lawsuits in federal district court within one year of the discriminatory action. Alternatively, you can go through the administrative process first and then file in court.

Under the Washington State Law Against Discrimination (RCW 49.60), employees have the choice of filing a complaint with the Washington State Human Rights Commission (HRC), or in

some cases a local human rights commission, or going directly to court. Complaints with the HRC must be filed within 180 days of the discriminatory action are all complaints filed with the HRC and/or EEOC are automatically considered to be jointly filed with each agency. The HRC will conduct an investigation and will issue a “cause” or “no cause” finding. Rather than filing with the HRC, the employee can hire an attorney and file a state law complaint under RCW 49.60 in court. Such claims must be filed within three years of the discriminatory action.

Before deciding what approach to use, employees should be aware that both the EEOC and the HRC have substantial case backlogs and it is not unusual to wait up to a year before an investigation is even initiated. The decision as to how to proceed can be an important one and employees may want to consult an attorney with expertise in employment or disability law before filing.

Under the ADA, Sections 501 and 504, and the Washington State Law Against Discrimination, employees may get injunctive relief—a court order to perform or not perform an act. This relief may include among other things, employment reinstatement, back pay, building modifications, hiring an employee to assist the individual, and provision of AT. Individuals may also receive compensatory damages for lost wages and for pain and suffering, and punitive damages, depending on whether the employer's discriminatory act is determined to have been intentional.¹¹

DIVISION OF VOCATIONAL REHABILITATION (DVR) AND DEPARTMENT OF SERVICES FOR THE BLIND (DSB)

At any time during the VR process, you have the right to appeal any decision by a counselor—including the denial of AT. It is always a good idea to start by talking with your counselor and trying to come to some mutually acceptable resolution. If you are still dissatisfied with the counselor's decision, you may discuss the issue with the counselor's supervisor who should provide a written decision after listening to you and the counselor.

If you want to appeal the supervisor's decision, you can request administrative review up to one year after the adverse decision. The request can be made to the district administrator orally or in writing. The request should include the reason for the appeal and the action that you think should be taken. A district administrator must conduct a review with you present, and send a written decision by certified mail within 15 days of the request for review. The written decision must inform you that, if dissatisfied, you may file a written request for a fair hearing within 30 days of receiving the decision.

The recently reauthorized Rehabilitation Act has added mediation as a dispute resolution option for individuals receiving VR services. Under the law, after an individual has requested a fair hearing and before it is conducted, either VR or the individual may request impartial mediation to attempt resolution before the fair hearing is held. The mediation must be completed before the fair hearing begins.¹²

Although legally you can request the fair hearing without going through the steps described above, it is usually in your best interest to take these “informal” appeal steps first. To request the fair

hearing, send a letter to the Director of DVR or the Director of DSB and state your reasons for the request. A hearing officer will be appointed to listen to both sides and make a decision. You may have an attorney or advocate with you at the hearing.

The written decision of the hearing officer is sent to the director of the VR agency who can review but not change the decision unless it is contrary to the law.¹³ It is the final decision unless you then file a lawsuit in court.

The Client Assistance Program (CAP) is also funded by the Rehabilitation Act. It is available to inform and advise all clients and applicants of all available benefits under DVR or DSB. Upon request, CAP can assist and advocate for clients or applicants regarding programs that provide vocational rehabilitation services and regarding other services that are directly related to facilitation of employment. CAP assists and advocates in pursuing legal, administrative or other appropriate remedies to ensure the protection of the rights of individuals. CAP also pursues access to services and funds through individual and systemic advocacy.¹⁴ Contact information for CAP is available in Appendix 1.

SOCIAL SECURITY ADMINISTRATION (SSA)

Any decision by the SSA concerning your eligibility or benefits can be appealed. If you are denied eligibility or are charged with an overpayment, you will receive a letter telling you about the denial or overpayment and how to go about appealing. As with all appeals, it is important that you read the letter and pay attention to any deadlines for appeal. SSA appeals include the right to a fair hearing before an ALJ. As with Medicaid and Medicare appeals, ALJs have historically reversed agency decisions in about half the cases. The hearings are designed to be informal and you do not have to be represented by a lawyer. However, having someone to advocate for you—either a lawyer or someone else who knows the process and procedures—might be very helpful for you. Contact WATA if you would like more information on lawyers who know Social Security law and may be available to help you.

When Social Security has denied a work incentive such as a PASS proposal, the first step should be to discuss the denial with your counselor or someone else who has worked with you on the proposal. You can give your reasons for disagreeing with the decision and hear the agency's reasons for denying the PASS. If your request is still denied after this informal meeting, you can ask for a written decision and begin the formal appeal process.

Please see the appeals discussion for Medicaid and Medicare earlier in this chapter for more information on appealing SSA decisions.

WORKERS' COMPENSATION—VOCATIONAL DISPUTE RESOLUTION OFFICE

In Washington state, the Vocational Dispute Resolution Office (VDRO) office in the Department of Labor and Industries (L&I) has the authority—on behalf of the L&I director—to review disputes related to a worker's ability-to-work determination or approved-return-to-work plan. The dispute resolution process requires that the worker send a written request for review of a

determination within 15 calendar days of the date the employer, worker or self-insured employer received notification of the determination, although there are extensions for good cause. The VDRO will review the dispute letter and other file information on the case. The office may conduct a phone investigation to determine and clarify facts. In addition, the office may schedule a mediation conference if the dispute involves issues that are negotiable.

Within 30 calendar days of receiving the dispute, the L&I director must issue a decision in response.¹⁵ There are two categories of decisions. Some decisions are made by the director if no more information required. Decisions that require more information or involve a negotiated decision by all parties are issued by the VDRO reviewer on behalf of the director.

It is important to remember that in Washington state, the decision of whether a worker is eligible for vocational benefits is considered a discretionary—not mandatory—decision on the part of the L&I director. However, you can appeal the director's decision to the Board of Industrial Insurance Appeals on an abuse of discretion standard.

VI. C. EDUCATION-RELATED SOURCES OF AT FUNDING

PUBLIC PRIMARY AND SECONDARY EDUCATION IDEA, ADA AND SECTION 504

IDEA

You have several options for appeal if you are unsuccessful in getting the school district to provide AT that you think is required to ensure your child receives FAPE. Although you can file a lawsuit against the school district, the law requires that you exhaust the administrative due process procedures before filing suit. For students who are IDEA-eligible, the administrative process includes mediation and due process hearings.

Mediation is an informal voluntary process for parents and school districts to resolve disagreements about a student's special education assessment, program, or placement with the assistance of an impartial third person. You can request mediation and the school district is obligated to inform you about this due process option. Regardless of whether an agreement is reached through mediation, either party still has the right to request a due process hearing. Mediation may be used before or during a request for hearing. It need not interrupt your request for a due process hearing, and cannot be used to deny or delay access by a parent to a due process hearing.¹⁶ Attorneys cannot participate in the mediation but may be available for consultation during the mediation. Mediation is paid for by the Office of Superintendent of Public Instruction (OSPI).

Because mediation is not a required administrative complaint step, you can skip it if you choose and ask for a due process hearing. Alternatively you can first go through mediation and then file for the hearing. To initiate a request for a due process hearing, you should send a request in writing to the school district superintendent. The request should be sent by certified or registered mail or can be hand-delivered. Due process hearings are conducted at the expense of OSPI by a

Washington state ALJ who serves as the hearing officer. An attorney may represent you at the hearing and, if you prevail, you may be awarded some or all of the attorney's "reasonable" fees.

The ADA and Section 504

Another appeal option is to file a compliance complaint with the U.S. Department of Education Office for Civil Rights (OCR). OCR focuses on a child's rights under Section 504 and the ADA rather than under IDEA. If the complaint is clearly a violation of an IDEA right, the agency may require that you exhaust the IDEA appeals process. However, a failure to provide AT may be a denial of rights under all three statutes and OCR may accept the complaint. If your child is served only under ADA and Section 504, OCR is the appropriate agency. Contact information for OCR is available in Appendix 1.

OCR will acknowledge the complaint within 15 days but may take up to 45 days to review it. If the school district is found to be out of compliance, OCR will seek voluntary compliance within 60 days. If the school does not comply, enforcement measures will be initiated within 30 days. Generally OCR is successful at resolving the complaint without resorting to litigation, but litigation is a possible avenue in the appeals process.

PRIVATE PRIMARY AND SECONDARY SCHOOLS

Students with disabilities who attend private primary and secondary schools have the rights to appeal as described in the ADA, Section 504 and RCW 49.60 assuming that their schools are covered by these laws. Title III of the ADA provides that individuals can file a complaint for a violation of the statute without exhausting administrative remedies first. The remedies that can be available include requiring the provision of an auxiliary aid or service—AT. In addition, the state Attorney General may also file a court complaint when there is a violation that raises an issue of public importance. Complaints under RCW 49.60 should be made with the HRC as described in section C. of this chapter.

POST-SECONDARY EDUCATION

Many students who require AT in the post-secondary setting will have those devices or services funded by one of the major funding sources discussed above—such as private insurance, Medicaid, Social Security or a VR agency. Any appeal regarding AT funded under these sources should follow the procedures for that particular agency.

However, institutions of higher education themselves have responsibilities under federal and state law to provide AT in certain circumstances and in some cases students will want to request a review of a decision by the institution. The specifics of the appeal process will differ somewhat in each institution and depending on the decision is based upon federal or state law. Therefore, students who want to appeal institutional decisions regarding AT should contact the disabled students' services office on campus and request information on the appropriate procedure to follow. As with all appeals process, it is usually advantageous to pursue administrative reviews first before filing a complaint in court. If a student continues to be dissatisfied with an internal

institutional decision, he or she can file a complaint with the appropriate administrative agency—such as the HRC or OCR—as well as file a court complaint.

VI. D. SPECIAL POPULATIONS

EARLY INTERVENTION SERVICES: PART C OF THE IDEA

If a family member does not agree with a decision concerning the early intervention services—such as AT—provided their child, the best first step is to talk with their family resources coordinator about the problem. If that is not successful, several options are available. Mediation is available at no cost to help resolve the problem. In addition, a family member can request a formal administrative hearing through the director of Early Intervention Services in the state office or the local early intervention services contractor. These names and addresses can be obtained from your family resources coordinator or you can call the state office for more assistance (Appendix 1).

VETERANS

Claimants for VA benefits can appeal any decision made by a VA regional office or medical center. An appeal of a VA decision must be made within one year of notification of the decision. The claimant should file a written notice of disagreement with the office that made the decision. After the office receives the notice, it will provide the veteran with a Statement of the Case setting forth the issue, facts, applicable law and regulations, and the reason for the determination. Within 60 days of receiving the Statement of the Case (or within one year from notice of the original determination, whichever is later), the veteran must file a Substantive Appeal with the Board of Veterans Appeals.

A Board of Veterans Appeals hearing can be held either in Washington, DC or at a VA regional office. Claimants may be represented by an advocate or an attorney. The Board of Appeals will conduct the appeal and issue a written decision about the veteran's benefits.

A veteran may appeal a Board of Veterans Appeals decision to the Court of Veterans Appeals, which is a seven-judge court independent from Veterans Affairs. An appeal must be filed with the Court within 120 days of the date the Board mailed its final decision. The Court will review the record that was available to the Board but will not hear new evidence. Either party may appeal the Court's decision to the U.S. Federal Court of Appeals and to the U.S. Supreme Court. For more information about the Court's rules and procedures, contact the clerk's office (Appendix 1).

TRICARE

If TRICARE users are denied benefits they think they are entitled to, they can appeal the denial decision to both the TRICARE contractor/provider or the TRICARE Support Office (TSO)—formerly known as the CHAMPUS headquarters. The following information describes the TRICARE appeals procedures applicable to the routine processing of TRICARE Standard claims and authorization of care. However, TRICARE managed-care contracts and the appeals

procedures that TRICARE contractors/providers use in these areas may vary from the procedures described below.

When you receive a denial of services, the denial should include specific notice of your right to appeal, including the address of the next level of appeal. If you have any questions about your right to appeal and the specific notice of your appeal rights included on a TRICARE Standard decision, check with your TRICARE contractor/provider for more information.

Generally, there are three possible levels of review under TRICARE Standard appeal procedures. The levels available in any particular case will be specified in the notice of your right to appeal a particular decision. The three levels include:

- 1) reconsideration, conducted by the TRICARE contractor/provider responsible for the decision in a particular case;
- 2) formal review, conducted by a contractor or by the TSO; and
- 3) a hearing administered by the TSO, but conducted by an independent hearing officer.

If you disagree with a decision that comes back on the Explanation of Benefits (EOB) or some other decision by the TRICARE contractor, write to the TRICARE contractor, or to the address specified in the notice of your right to appeal or included in your EOB. Your letter must be postmarked or received by the TRICARE contractor within 90 days of the date on the EOB or the notice with which you disagree. Be sure to include a copy of the EOB or notice, as well as any other information or papers to support your reason for disagreeing with the decision.

The TRICARE contractor will review the case and will issue a “reconsideration decision.” If the amount in dispute is less than \$50, the reconsideration by the TRICARE contractor is final. If you still disagree, and if \$50 or more is in dispute, you can ask the TSO for a formal review.

Write to the TSO, making sure your letter is postmarked within 60 days of the date on the notice of reconsideration decision with which you disagree. If you have them, be sure to include a copy of the notice as well as any other information or papers to support your position. But even if you don't have some of the supporting papers, send your letter anyway, to meet the deadline requirements. Send the other documents when you get them. Your request for a formal review should be sent to the TRICARE Support Office (the address is listed in Appendix I). The TSO will review the case and issue a formal review decision. If the amount in dispute is less than \$300, the formal review decision by the TSO is final. If you still disagree and if \$300 or more is in dispute, you can ask the TSO to schedule an independent hearing.

The formal review decision explains the steps for requesting a hearing. These steps extend to the point that the TSO Director or the Assistant Secretary of Defense for Health Affairs makes a final decision. A hearing is conducted by an independent hearing officer at a location convenient to both the requesting party and the government.

If your appeal concerns a decision by the TRICARE contractor, you must ask the contractor for a reconsideration before the TSO can do a formal review and your appeal usually must go through a formal review by the TSO before an independent hearing can be held.

Finally, if the claim is still denied, the user may choose to take TRICARE or the Department of Defense to court.¹⁷

RESIDENTIAL CARE

The Washington State Long-Term Care Ombudsman is a mandated service under the Older Americans Act. The ombudsman is intended to improve the quality of life for people who live in long-term care facilities, including nursing homes, boarding homes, adult family homes and veteran's homes.

The ombudsman is an impartial mediator with the duty to be sure that residents of long-term care receive fair treatment and have access to information about their rights and available resources. The ombudsman's office is available to assist anyone in the state who has questions about laws, regulations, mediation, and appeals processes. The ombudsman's specific responsibilities include the following, which may be helpful in obtaining AT: 1) listening to complaints about nursing homes, boarding homes and adult-family homes, and taking appropriate actions to resolve these complaints; 2) assisting nursing-home, boarding-home and adult-family-home residents to obtain the legal, financial, social, recreational, physical and emotional services to which they are entitled; and 3) assisting the operators and staff of long-term care facilities to meet the needs and concerns of those who live there.

In addition, the office can provide individual advocacy for those who choose to file a formal complaint. If you believe that you or someone you know living in a residential facilities has been denied appropriate AT, call the Washington State Long-Term Care Ombudsman Program (Appendix 1). The state ombudsman is located at the South King County Multi-Services Center. Regional long-term care ombudsmen are located throughout Washington state. If you have a concern call the state office for the location of the regional office closest to you.

If the complaint concerns fees, procedures, or provision of services—such as AT—the ombudsman may assist you. However, if the complaint regards abuse, the ombudsman will refer your call to DSHS or you may call the DSHS Residential Care Services Complaints line directly. Only DSHS is authorized to handle complaints of abuse and all such complaints must be referred to them.

CHAPTER VI NOTES

¹ *McGraw v. The Prudential Insurance Company of America*, 137 F.3d 1253 (10th Cir. 1998); *Bedrick v. Travelers Insurance Company*, 93 F.3d 149 (4th Cir. 1996).

² The materials in this section were prepared by Evergreen Legal Services Program (now Columbia Legal Services).

³ 42 United States Code (U.S.C.) § 405(g).

⁴ 42 Code of Federal Regulations (C.F.R.) § 405.807(c).

⁵ 42 C.F.R. §§ 405.815; 405.821.

⁶ Call local EEOC office found in government pages of phone book or call 800-669-4000, 800-800-3302(TDD).

⁷ 42 U.S.C. § 2000e-5(e)(1).

⁸ 42 U.S.C. § 2000e-5(f)(1).

⁹ 29 C.F.R. § 1614.105(a)(1).

¹⁰ 29 C.F.R. § 1614.105(d).

¹¹ 42 U.S.C. § 2000g(1).

¹² 29 U.S.C. § 722(c)(4).

¹³ 29 U.S.C. § 722 (c)(5)(D)-(F).

¹⁴ 29 U.S.C. § 732.

¹⁵ Washington Administrative Code (WAC) 296-18A-470.

¹⁶ WAC 392-172-310.

¹⁷ TRICARE Handbook <http://www.tricare.osd.mil/TricareHandbook/>.

CHAPTER VII

ALTERNATIVE SOURCES OF ASSISTIVE TECHNOLOGY FUNDING AND TAX INCENTIVES

This chapter describes a number of alternative funding sources. Some of the options described below may be appropriate for you. For individuals who currently use or need AT in an employment setting, the tax incentives available to either employees or employers may help you to purchase AT or at least to offset its cost.

VII. A. PRIVATE BANK LOANS

Banks represent an important—and sometimes forgotten—resource for acquiring AT. Some banks advertise “access” loan programs, which are intended to help individuals with disabilities purchase vans and vehicle modifications, home modifications and AT. In Washington state, none of these loan programs offer lower than market interest rates. If you apply for one of these loans, you must meet the typical qualification requirements for any bank loan. If your bank does not have a designated loan program for AT, ask about other packages that might be helpful to you. Some banks have special programs for low-income consumers for which you might qualify. You also may be able to get a home equity loan to purchase needed AT. If you encounter difficulties in qualifying for a bank loan, please feel free to call WATA.

VII. B. COMMUNITY SERVICE ORGANIZATIONS

Service organizations and clubs (such as the Elks, Rotary, Soroptomist and Lions Clubs) and churches represent another important source of funding for AT. Many community organizations have funds to help people in need. To request information on an organization’s guidelines for funding, contact the president of the local chapter or the administrative office. If you are personally acquainted with someone in the club or church, ask him or her for specific suggestions on approaching the organization with your AT request.

VII. C. USED AND RECYCLED EQUIPMENT

Used AT equipment can often be obtained at reduced or no cost. To locate used equipment, contact local vendors or distributors of DME and other types of AT, check the classified ads in local newspapers, and contact computer recycling projects. For a resource list of agencies and organizations that distribute used computer equipment, visit the WATA Web site or call the Information and Referral (I&R) line (Appendix 1).

Another place to check for used equipment is the AT Exchange, an online database to facilitate exchange, sale, and/or donation of AT devices. The database helps people find other users for AT that they no longer need and allow those who need a device to acquire it more quickly. The database is maintained by the University of Washington Center for Technology and Disability. To access the Exchange, visit the WATA Web site and choose the AT Exchange Link. If you do not

have access to the Web and would like use the database, you can do so by calling the University of Washington Center for Technology and Disability (Appendix 1).

VII. D. PRIVATE TRUSTS AND FOUNDATIONS

Trusts and foundations manage funds established to aid or support certain types of activities by awarding grants to specific organizations or individuals. All such entities have specific rules regarding who can receive a grant and the purposes for which it can be used. Most trusts or foundations will only take applications from organizations, although there are some that will accept requests from individuals. Locating such a trust or foundation is not easy, but you might investigate the options for AT funding in *The Foundation Directory*, a listing of trusts and foundations organized by state and city. This book can be found at public libraries.

Local foundations are a good place to begin because they are less likely to be inundated by requests and therefore more likely to consider yours. Remember, every trust or foundation has criteria that the applicant must meet in order to be considered for assistance—e.g., geographic, financial, age or other requirements. The trust or foundation listing will have the name of a contact person, and this individual can provide details of the application process.

VII. E. INCOME AND BUSINESS TAX INCENTIVES

Although tax incentives are not a source of funding AT *per se*, they can help defray the cost of AT—either for the employee for work-related expenses or for business operators and employers for costs related to complying with state and federal nondiscrimination laws.

IMPAIRMENT-RELATED WORK EXPENSES (IRWE)

If you are an employee and have a physical or mental impairment that functionally limits one or more of your major life activities—including working—you may be able to claim impairment-related work expenses (IRWE) that can lower your total federal tax bill. You do not have to be receiving SSA benefits to benefit from this tax deduction. In general, allowable expenses include those that are:

- Necessary for you to do your work satisfactorily
- For goods and services not required or used (other than incidentally) in your personal activities
- Not specifically covered under other income tax laws

Employee business expenses are generally subject to a 2% of adjusted gross income limit; however, because this limit does not apply to IRWE this deduction can significantly lower total tax liability. IRWE is discussed in more detail in Chapter III.

If you have IRWE, complete Form 2106, Employee Business Expenses, or Form 2106-EZ, Unreimbursed Employee Expenses, and attach it to your Form 1040.

BUSINESS TAX INCENTIVES

If you own or operate a business, you should be aware of three tax incentives for helping persons with disabilities. They are:

Deduction for costs of removing architectural or transportation barriers

This is a tax deduction you can take for making your facility or public transportation vehicle more accessible to and useable by persons who have disabilities or are elderly. See Chapter 11 in IRS Publication 535, *Business Expenses*.

Disabled Access Tax Credit

This credit is for expenses incurred to provide access to persons with disabilities. See Chapter 4 General Business Credit & Electric Vehicle Credit in IRS Publication 334, *Tax Guide for Small Business*.

Work Opportunity Tax Credit

This credit is for wages paid to persons in targeted groups that have a particularly high unemployment rate or other special employment needs. See Chapter 4 in IRS Publication 334 *Tax Guide for Small Business* for more information.¹

¹ For IRS publications and forms call: 800-TAX-FORM (800-829-3676).

Appendix 1

RESOURCES

The following resource information was current at the time of publication.

ABA Commission on Mental and Physical Disability Law
<http://www.abanet.org/disability/>

ABLEDATA

8455 Colesville Road, Suite 935

Silver Spring, MD 20910

800-227-0216 or 301-608-8998 (V/TTY)

FAX: 301-608-8958

Ask to speak with an information specialist. Hours of service are 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday, except federal holidays. You can also fax or mail a written request.

<http://www.abledata.com/index.htm>

ADA Document Center

<http://janweb.icdi.wvu.edu/kinder/>

Aging and Adult Services Administration

800-737-0617

<http://www.aasa.dshs.wa.gov/>

American Council on Education's HEATH Resource Center

<http://www.acenet.edu/about/programs/Access&Equity/HEATH/>

University of Washington Center for Technology and Disability

800-841-8345 V/TTY (toll free)

206-685-4181 V/TTY

206-616-1296 TTY

uwat@u.washington.edu (email)

<http://wata.org/>

Basic Health Plan (BHP)

The BHP handbook can be found on the Web at

<http://www.wa.gov/hca/basicpubs/Webqa.htm>

Blue Cross/Blue Shield of North Dakota

800-444-4606

<http://www.noridian.com/medweb/>

Children's Alliance

206-324-0340

<http://www.childrensalliance.org>

Children's Health Insurance Program (CHIP)

<http://maa.dshs.wa.gov/CHIP/Index.html>

CIGNA

P.O. Box 690
Nashville, TN 37202
615-251-8182 or 800-899-7095
<http://www.cignamedicare.com/>

Client Assistance Program (CAP)

531 Rainier Avenue South
Seattle, Washington 98144
206-721-5999, in the Seattle area
800-544-2121, toll-free statewide

Eligibility: Must be an individual receiving or seeking services from DSB or DVR.

Court of Veterans Appeals

Clerk's office:
625 Indiana Ave. NW, Suite 900
Washington, D.C. 20004
800-869-8654

Department of Labor & Industries (L&I)

800-LISTENS (800-547-8367)
<http://www.wa.gov/lni/insurance/>

Department of Services for the Blind (DSB)

3411 South Alaska Street
Seattle, WA 98118
206-721-4422 (voice)
206-721-4056 (TTY)
800-552-7103 (voice only)
<http://www.wa.gov/dsb/>

Department of Vocational Rehabilitation (DVR)

PO Box 45340
Olympia, WA 98504-5340
800-637-5627
<http://www.wa.gov/dshs/dvr/>

Disabled American Veterans

<http://www.dav.org/>

Disabled American Veterans of Washington

http://members.tripod.com/WA_DAV/

Division of Developmental Disabilities (DDD)

<http://www.wa.gov/dshs/ddd/>

Applications for DDD services can be made at local DDD offices. A list of local offices is available on the Web at:

<http://www.wa.gov/dshs/ddd/4org.html>

DO-IT (University of Washington)
<http://www.washington.edu/doit>

Early Intervention Services
 “Healthy Mothers, Healthy Babies”
 800-322-2588 (V) or 800-833-6384 (TDD)

Equal Employment Opportunity Commission (EEOC)
<http://www.eeoc.gov/>

Federal Employees Health Benefits
<http://www.opm.gov/insure/index.html>

Health Care Financing Administration (HCFA)
<http://www.hcfa.gov/>
 Medicare Part A: 425-670-1010
 Medicare Part B: 800-444-4606

Healthy Mothers, Healthy Babies Line
 see Early Intervention Services

Healthy Options Hotline
 800-546-5015

High Risk Pool
 800-562-6900 toll free statewide
 Related information is available at the following Web sites:
<http://www.insure.com/states/wa/health/riskpool599.html>
<http://www.help-for-health.org/>

Infant Toddler Early Intervention Program (ITEIP)
 360-902-8488 (V) or 360-902-7864 (TDD)
<http://www.wa.gov/dshs/iteip/iteip.html>

Information and Referral (I&R)
 WATA
 800-214-8731 (V/TTY)

Job Accommodation Network
 800-526-7234 (V/TTY)
<http://janweb.icdi.wvu.edu/>

Long-Term Care Ombudsman Program
 800-562-6078 (voice)
 800-737-7931 (TTY)

Medicaid
 see Medical Assistance Administration

Medical Assistance Administration (MAA)

800-546-5015 or 800-562-3022

<http://www.wa.gov/dshs/maa2/maa2hp.html>

Local Community Service Offices (CSOs) are listed on the Web at:

<http://www.wa.gov/dshs/geninfo/map3.html>

Washington Medicaid's policies with respect to DME and other benefit categories can be found in its billing instructions on the Web at:

<http://maa.dshs.wa.gov/index.html>

Fair hearing coordinator:

P.O. Box 45530

Olympia, Washington 98504-5530

360-664-2304

Neighborhood Legal Services (NLS)

716-847-0650 (V) or 716-847-1322 (TTY) to request copies of their November 1996 and November 1998 articles on vocational rehabilitation funding of AT

<http://www.nls.org>

State Vocational Rehabilitation Agencies and Their Obligation to Maximize Employment

<http://www.nls.org/vrbooklt.htm>

The Public School's Special Education System as a Funding Source: The Cutting Edge

<http://www.nls.org/specedat.htm>

Office for Civil Rights

U.S. Department of Education

Office for Civil Rights

Region X Office

915 Second Avenue, Suite 3310

Seattle, Washington 98174-1099

206-220-7900 (voice)

206-220-7907(TTY)

Office of Administrative Hearings

P.O. Box 2465

Olympia, WA 98504

360-664-8717

206-464-6322 in Seattle

800-583-8270

Office of the Insurance Commissioner

800-562-6900

<http://www.insurance.wa.gov>

Office of the Superintendent of Public Instruction (OSPI)

Old Capitol Building

P.O. Box 47200

Olympia, WA 98504

360-753-6738 (voice)

360-664-3631 (TDD)

<http://www.k12.wa.us/>

Information about home-based instruction:

<http://www.k12.wa.us/homebased/>

Information about private school education:

http://inform.ospi.wednet.edu/support_services/PrivateSch.html

Premiera Blue Cross of Washington

206-670-5900 or 800-345-6784

<http://www.premiera.com/bcwa/>

Regency BlueShield of Washington

206-626-6265

Residential Care Services Complaint Line

800-562-6078 (voice)

800-737-7931 (TTY)

Social Security Administration

800-722-1213 (V)

800-325-0778 (TDD)

<http://www.ssa.gov/>

Statewide Health Insurance Benefits Advisors (SHIBA)

800-397-4422

<http://www.shiba.org/>

TRICARE

TRICARE Support Office

Appeals

Aurora, CO 80045-6900

<http://www.tricare.osd.mil/tricare/beneficiary/hptriben.html>

THE TRICARE Northwest Web site is:

<http://tricarenw.mamc.amedd.army.mil/>

There are twelve Health Services Regions designated by the Department of Defense (DOD). Washington is within Region 11, and the regional center is located at Madigan Army Medical Center in Tacoma, Washington 98431-5000. Phone 800-404-0110 for more information.

U.S. Department of Education

Web site containing copies of IDEA regulations:

<http://www.ed.gov/offices/OSERS/IDEA/regs.html>

U.S. Office of Personnel Management

FEHBP Web site:

<http://www.opm.gov/insure/index.html>

Veterans Affairs (VA)

Regional Office:

Department of Veterans Affairs

915 Second Avenue

Seattle, Washington 98174

206-624-7200 or 800-827-1000 (toll-free, statewide)

<http://www.va.gov/>

Local Veterans Centers:

Seattle: 2230 8th Avenue, 98121 (206-553-2706)

Spokane: W. 1708 Mission St., 99201 (509-327-0274)

Tacoma: 4916 Center St., Suite E, 98409 (253-565-7038)

Washington Assistive Technology Alliance (WATA)

Policy and funding analysis; legislation; technical consultation and training; publications, and electronic resources:

The University of Washington Center for Technology and Disability

800-841-8345 V/TTY

206-685-4181 V/TTY

206-616-1396 TTY

uwat@u.washington.edu (email)

<http://wata.org>

Statewide Information and Referral:

800-214-8731 V/TTY

Washington Disability Law Resources List

<http://wata.org/resource/legal/index.htm>

Washington Protection and Advocacy System (WPAS)

180 W. Dayton, Suite 109

Edmonds, WA 98020-4127

800-562-2702 (V/TTY)

425-776-1199 (V/TTY)

<http://www.halcyon.com/wpas/>

Appendix 2

SAMPLE LETTER OF JUSTIFICATION

Date

Addressee:

Re: Consumer's Name
Social Security Number
Policy or Account Number

Dear (name of Medical Consultant, Vocational Rehabilitation Counselor, Personal Care Representative, Special Education Director, etc.):

Paragraph One: Short Introduction

One or two sentences about the device and services requested and why they are needed. Identification of supporting documentation included as enclosures (AT professional evaluation, price quotation from vendor, letters of medical necessity from specialists, brochure or other information showing device).

Paragraph Two: Information About the Consumer

Personalize the consumer: provide information needed to acquaint the funding source's decision-maker with the situation and requirement for AT. Include the following, as appropriate:

1. Name, age, sex, diagnosis
2. Current housing status (where does consumer live and with whom; availability of, or need for, personal assistance)
3. Current school or employment status
4. Primary care physician, hospital and clinic affiliation as appropriate
5. Diagnosis, expected clinical course and prognosis. Be as specific and inclusive as possible. Address changes in condition; height and weight comparisons; planned or completed surgeries; X-ray findings and other relevant medical diagnostic testing as appropriate.
6. Information regarding functional limitations associated with the diagnosis
7. AT history
8. Current equipment and experiences in using that equipment
9. Cognitive status
10. Describe efforts to obtain funding through other sources

Paragraph Three: Equipment Requested

Describe the equipment needed in detail. A request that simply states "electric wheelchair" or "augmentative communication system" will not be adequate because there are many different varieties of communications systems and power chairs. Address the need for any added components (e.g., cushions, joysticks, positioning belts, mounting devices, etc.). Discuss duration of expected usage of equipment. Describe the consumer's actual experience and success in using the device. Show the functional benefits of the equipment to the consumer; tell the decision-maker what the equipment will allow the consumer to do. You may want to include a picture or video of the consumer using the device.

Explain why other devices were ruled out—especially less expensive devices. Express the need for the device in language that targets the funding source's criteria. For example, language such as: "medical necessity," "achieving a free and appropriate public education," or "overcoming barriers to employment." Describe why the device is not an item of convenience.

Consider addressing the following rationales:

1. Is the device needed to prevent further injury or pain? Is it a cost-effective means of preventing secondary complications or further functional limitations?
2. Is the device needed for effective communication including communication for medical purposes?

3. Is the device needed for safety?
4. What is the impact of the device on the consumer's mental health? How does the consumer's mental health impact medical, educational, vocational status?
5. Will the device reduce dependence upon other services funded by this agency such as nursing care or hospitalization?
6. Is the device a substitute—in effect, a prosthetic or orthotic device—for a lost functional capability such as vision or hearing or mobility?
7. Will the device allow the consumer to resume or improve his employment?
8. Will the device allow the consumer to continue to live at home instead of in a nursing home or hospital?
9. Will it allow the consumer to meet educational goals?

Mention potential for growth-modification and adjustments that will ensure long-term use of device. Describe the cost of the equipment and why the particular vendor was chosen. For example: good reputation, experience with that vendor, preferred provider with your insurer, only vendor in town.

Paragraph Four: Needed Support Services Or Plans for Evaluation

Describe any needed support services such as training, maintenance and repairs and how these services will be funded, including contributions from any other funding sources.

Paragraph Five: Summary

Identify enclosures if you have not already done so. Identify whom to contact for additional information or questions.

Closure

Thank the agency for its time in reviewing the request. Provide co-signatures of appropriate medical or vocational professionals.

Sample enclosures:

1. Letters from primary care physician and specialists
2. AT evaluation documents
3. Photographs or videos showing consumer using the requested device
4. Information from vendor on device and costs
5. Brochures or letters describing requested AT device
6. Any required agency forms
- 7.



U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)



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